

4204

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4629 Henderson Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Augustus</u> Middle <u>John</u> Last <u>ADAMS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>			
11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Lorenzo Adams</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fagan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-I & II</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>(Daughter) Mrs. Alice C. Swanick (Same As #2)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopulmonary suppurative disease</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Organism not determined.</u> <u>Chronic bronchitis and obstructive emphysema + 14 years.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>10</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 April</u> , 19 <u>57</u> , to <u>16 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>57</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harold I. Passes</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-17-57</u>							
ACTUAL SIGNATURE <u>Harold I. Passes, LT, MC, USN</u> U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) <u>Harold I. Passes, LT, MC, USN</u> U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL HOME <u>Fitzgerald Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>4-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF JUDGE</p>		<p>15. SIGNATURE OF CLERK</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF JUDGE</p>		<p>20. SIGNATURE OF CLERK</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESS</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF JUDGE</p>		<p>25. SIGNATURE OF CLERK</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESS</p>		<p>28. SIGNATURE OF PHYSICIAN</p>		<p>29. SIGNATURE OF JUDGE</p>		<p>30. SIGNATURE OF CLERK</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF PHYSICIAN</p>		<p>34. SIGNATURE OF JUDGE</p>		<p>35. SIGNATURE OF CLERK</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESS</p>		<p>38. SIGNATURE OF PHYSICIAN</p>		<p>39. SIGNATURE OF JUDGE</p>		<p>40. SIGNATURE OF CLERK</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESS</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF JUDGE</p>		<p>45. SIGNATURE OF CLERK</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF PHYSICIAN</p>		<p>49. SIGNATURE OF JUDGE</p>		<p>50. SIGNATURE OF CLERK</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESS</p>		<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF JUDGE</p>		<p>55. SIGNATURE OF CLERK</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESS</p>		<p>58. SIGNATURE OF PHYSICIAN</p>		<p>59. SIGNATURE OF JUDGE</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF JUDGE</p>		<p>65. SIGNATURE OF CLERK</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESS</p>		<p>68. SIGNATURE OF PHYSICIAN</p>		<p>69. SIGNATURE OF JUDGE</p>		<p>70. SIGNATURE OF CLERK</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESS</p>		<p>73. SIGNATURE OF PHYSICIAN</p>		<p>74. SIGNATURE OF JUDGE</p>		<p>75. SIGNATURE OF CLERK</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF PHYSICIAN</p>		<p>79. SIGNATURE OF JUDGE</p>		<p>80. SIGNATURE OF CLERK</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESS</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF JUDGE</p>		<p>85. SIGNATURE OF CLERK</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESS</p>		<p>88. SIGNATURE OF PHYSICIAN</p>		<p>89. SIGNATURE OF JUDGE</p>		<p>90. SIGNATURE OF CLERK</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF JUDGE</p>		<p>95. SIGNATURE OF CLERK</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESS</p>		<p>98. SIGNATURE OF PHYSICIAN</p>		<p>99. SIGNATURE OF JUDGE</p>		<p>100. SIGNATURE OF CLERK</p>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>11606 Ashley Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>—</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louie</u> XXXXX		14. MOTHER'S MAIDEN NAME <u>Unknown Sophie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Reg.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL ANEURYSM</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARTIAL SMALL INTESTINAL OBSTRUCTION.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>4-23</u> , 19 <u>57</u> , to <u>4-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>57</u> , and that death occurred at <u>6:25</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. C. Carrick</u>		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville Md.</u>	
DATE <u>4/25/57</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		24a. REC'D BY REGISTRAR <u>J. Stansbury</u>	
ADDRESS <u>6411 Windsor Mill Rd.</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 29 1957

APR 29 1957

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4205

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8810 Georgia Ave.</u>		d. STREET ADDRESS <u>18810 Georgia Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>HOWARD</u> Middle <u>ARMSTRONG</u> Last <u>ARMSTRONG</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/3/88</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM A. ARMSTRONG</u>		14. MOTHER'S MAIDEN NAME <u>KATE SNYDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWA</u>		16. SOCIAL SECURITY NO. <u>225-22-8693</u>	
17. INFORMANT Address <u>Mrs. Gladys L. Armstrong, 11,109 Midvale Rd. Kensington, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 28, 1957</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 Georgia Ave. Silver Spring Md 4/1/57</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Francis J. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 10 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 42:6 CERTIFICATE OF DEATH

04175
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9516 THORNHILL ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JESSIE Middle PRATT Last BARNUM				4. DATE OF DEATH Month APRIL Day 29 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1858		9. AGE (In years last birthday) yrs. 98	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PRATT				14. MOTHER'S MAIDEN NAME CHARITY CHURCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. John F. McClelland, 9516 Thornhill Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Hip - July 1956							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home			
20c. TIME OF INJURY Month, Day, Year Hour o. m. July 1956 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Silver Spring Montgomery Md.	
21. I certify that I attended the deceased from June 1951 , to April 29, 1957 , that I last saw the deceased alive on April 22, 1957 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8248 Georgia Ave. Silver Spring, Md. DATE SIGNED 4/29/57							
ACTUAL SIGNATURE Merrill M. Cross M.D.				PHYSICIAN'S NAME (Type) MERRILL M. CROSS M.D. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 5/3/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY OAKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) TROY, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 3/4/57	
				24b. REGISTRAR'S SIGNATURE James Potter			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED STANLEY, WILLIAM		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH JULY 22, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. H. SMITH	
10. SIGNATURE OF REGISTRAR J. H. SMITH		11. SIGNATURE OF WITNESSES J. H. SMITH		12. SIGNATURE OF DECEASED J. H. SMITH	
13. SIGNATURE OF DECEASED J. H. SMITH		14. SIGNATURE OF DECEASED J. H. SMITH		15. SIGNATURE OF DECEASED J. H. SMITH	
16. SIGNATURE OF DECEASED J. H. SMITH		17. SIGNATURE OF DECEASED J. H. SMITH		18. SIGNATURE OF DECEASED J. H. SMITH	
19. SIGNATURE OF DECEASED J. H. SMITH		20. SIGNATURE OF DECEASED J. H. SMITH		21. SIGNATURE OF DECEASED J. H. SMITH	
22. SIGNATURE OF DECEASED J. H. SMITH		23. SIGNATURE OF DECEASED J. H. SMITH		24. SIGNATURE OF DECEASED J. H. SMITH	
25. SIGNATURE OF DECEASED J. H. SMITH		26. SIGNATURE OF DECEASED J. H. SMITH		27. SIGNATURE OF DECEASED J. H. SMITH	
28. SIGNATURE OF DECEASED J. H. SMITH		29. SIGNATURE OF DECEASED J. H. SMITH		30. SIGNATURE OF DECEASED J. H. SMITH	
31. SIGNATURE OF DECEASED J. H. SMITH		32. SIGNATURE OF DECEASED J. H. SMITH		33. SIGNATURE OF DECEASED J. H. SMITH	
34. SIGNATURE OF DECEASED J. H. SMITH		35. SIGNATURE OF DECEASED J. H. SMITH		36. SIGNATURE OF DECEASED J. H. SMITH	
37. SIGNATURE OF DECEASED J. H. SMITH		38. SIGNATURE OF DECEASED J. H. SMITH		39. SIGNATURE OF DECEASED J. H. SMITH	
40. SIGNATURE OF DECEASED J. H. SMITH		41. SIGNATURE OF DECEASED J. H. SMITH		42. SIGNATURE OF DECEASED J. H. SMITH	
43. SIGNATURE OF DECEASED J. H. SMITH		44. SIGNATURE OF DECEASED J. H. SMITH		45. SIGNATURE OF DECEASED J. H. SMITH	
46. SIGNATURE OF DECEASED J. H. SMITH		47. SIGNATURE OF DECEASED J. H. SMITH		48. SIGNATURE OF DECEASED J. H. SMITH	
49. SIGNATURE OF DECEASED J. H. SMITH		50. SIGNATURE OF DECEASED J. H. SMITH		51. SIGNATURE OF DECEASED J. H. SMITH	
52. SIGNATURE OF DECEASED J. H. SMITH		53. SIGNATURE OF DECEASED J. H. SMITH		54. SIGNATURE OF DECEASED J. H. SMITH	
55. SIGNATURE OF DECEASED J. H. SMITH		56. SIGNATURE OF DECEASED J. H. SMITH		57. SIGNATURE OF DECEASED J. H. SMITH	
58. SIGNATURE OF DECEASED J. H. SMITH		59. SIGNATURE OF DECEASED J. H. SMITH		60. SIGNATURE OF DECEASED J. H. SMITH	
61. SIGNATURE OF DECEASED J. H. SMITH		62. SIGNATURE OF DECEASED J. H. SMITH		63. SIGNATURE OF DECEASED J. H. SMITH	
64. SIGNATURE OF DECEASED J. H. SMITH		65. SIGNATURE OF DECEASED J. H. SMITH		66. SIGNATURE OF DECEASED J. H. SMITH	
67. SIGNATURE OF DECEASED J. H. SMITH		68. SIGNATURE OF DECEASED J. H. SMITH		69. SIGNATURE OF DECEASED J. H. SMITH	
70. SIGNATURE OF DECEASED J. H. SMITH		71. SIGNATURE OF DECEASED J. H. SMITH		72. SIGNATURE OF DECEASED J. H. SMITH	
73. SIGNATURE OF DECEASED J. H. SMITH		74. SIGNATURE OF DECEASED J. H. SMITH		75. SIGNATURE OF DECEASED J. H. SMITH	
76. SIGNATURE OF DECEASED J. H. SMITH		77. SIGNATURE OF DECEASED J. H. SMITH		78. SIGNATURE OF DECEASED J. H. SMITH	
79. SIGNATURE OF DECEASED J. H. SMITH		80. SIGNATURE OF DECEASED J. H. SMITH		81. SIGNATURE OF DECEASED J. H. SMITH	
82. SIGNATURE OF DECEASED J. H. SMITH		83. SIGNATURE OF DECEASED J. H. SMITH		84. SIGNATURE OF DECEASED J. H. SMITH	
85. SIGNATURE OF DECEASED J. H. SMITH		86. SIGNATURE OF DECEASED J. H. SMITH		87. SIGNATURE OF DECEASED J. H. SMITH	
88. SIGNATURE OF DECEASED J. H. SMITH		89. SIGNATURE OF DECEASED J. H. SMITH		90. SIGNATURE OF DECEASED J. H. SMITH	
91. SIGNATURE OF DECEASED J. H. SMITH		92. SIGNATURE OF DECEASED J. H. SMITH		93. SIGNATURE OF DECEASED J. H. SMITH	
94. SIGNATURE OF DECEASED J. H. SMITH		95. SIGNATURE OF DECEASED J. H. SMITH		96. SIGNATURE OF DECEASED J. H. SMITH	
97. SIGNATURE OF DECEASED J. H. SMITH		98. SIGNATURE OF DECEASED J. H. SMITH		99. SIGNATURE OF DECEASED J. H. SMITH	
100. SIGNATURE OF DECEASED J. H. SMITH		101. SIGNATURE OF DECEASED J. H. SMITH		102. SIGNATURE OF DECEASED J. H. SMITH	

RECEIVED
MAY 7 1957
BUREAU V. 2

4163 CERTIFICATE OF DEATH

Reg. Dist. No.

2V3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ITTakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Isaac</u> Last <u>Bassford</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/69</u>		9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA.</u>	
13. FATHER'S NAME <u>Jacob Bassford</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Wrenn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of kidneys</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atrophy due to arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>April 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 8, 1957</u> , 19 <u>57</u> , and that death occurred at <u>10:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u> M.D.				ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO, M.D.</u>				<u>TAKOMA PARK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>				ADDRESS <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR DATE <u>4/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4169

CERTIFICATE OF DEATH

04177

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16152</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>5403 Queens Chapel Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Marjorie Verline Bata</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-21</u>	9. AGE (In years lost birthday) <u>35</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HSWg OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry R House</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Phipps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post partum hemorrhage</u> <u>671.6</u> DUE TO <u>Placenta accreta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Massive intraperitoneal hemorrhage following hysterectomy for placenta accreta</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 14, 1956</u> , to <u>APRIL 22, 1957</u> , that I last saw the deceased alive on <u>APRIL 22, 1957</u> , and that death occurred at <u>7:37 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emma Hughes</u>				M.D. <u>TAKOMA PARK, MD.</u> DATE SIGNED <u>APRIL 22, 1957</u>			
PHYSICIAN'S NAME (Type) <u>EMMA HUGHES</u>				<u>WASHINGTON SANITARIUM, TAK. PK. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>APR 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. ...</u> ADDRESS <u>254 Carroll St NW.</u>				24a. REC'D BY REGISTRAR DATE <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>John P. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		1928		MOBILE		ALABAMA		U.S.A.		U.S.A.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
None		None		None		None		White		White		Brown		Blue	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS TENN		SHOOTING		SUICIDE		GUNSHOT WOUND		BLOOD POISONING		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		HOUR		MINUTE		SECOND		MILLISECOND		MICROSECOND		NANOSECOND	
APR 4 1968		10:00		AM		10:00		10:00		10:00		10:00		10:00	

BUREAU V. S.

APR 26 1968

RECEIVED

James Earl Ray

4207

CERTIFICATE OF DEATH

Reg. Dist. No.

211

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Beall				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1869	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jacob Hager				14. MOTHER'S MAIDEN NAME Sarah Ellen Gue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs W. Melvin Carlin, Boyds, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 10 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 10 , 19 46 to April 2 , 19 57 , that I last saw the deceased alive on March 31 , 19 57 , and that death occurred at 2:00 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr				DATE SIGNED 4/3/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Salem		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molesworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE April 4/57	
				24b. REGISTRAR'S SIGNATURE Della V. Burdette			

RECEIVED
APR 5 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boolesville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>John W. Williams</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Boolesville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W. Williams</u> Last 4. DATE OF DEATH <u>Apr 21</u> Month Day Year 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-19-1881</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>usc</u>			
13. FATHER'S NAME <u>Elmer Beall</u> 14. MOTHER'S MAIDEN NAME <u>Ida Eyles</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>J. M. Conner</u> Address <u>Boolesville md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-21-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>			
22d. LOCATION (City, town, or county) (State) <u>Boolesville md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Boolesville, md</u>					
24a. REC'D BY REGISTRAR <u>Charles W. Elgin</u>		24b. REGISTRAR'S SIGNATURE <u>per 4/22/57</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 24 1957

RECEIVED

4209

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3909 Washington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Gibson</u> Last <u>Beddie</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1904</u>		9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer (Composer)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>James Beddie</u>				14. MOTHER'S MAIDEN NAME <u>Annetta Swanson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>474-09-8930</u>		17. INFORMANT <u>Mrs. Elma Beddie</u> Address <u>Kensington, Md.</u> <u>3909 Washington St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA OF MALIGNANT</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF STOMACH WITH</u> DUE TO (c) <u>METASTASIS.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1956</u> to <u>April 29, 1957</u> , that I last saw the deceased alive on <u>April 28, 1957</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George Sharpe M.D.</u> M.D. <u>George Sharpe</u> <u>4/29/57</u> PHYSICIAN'S NAME (Type) <u>George Sharpe</u> <u>Kensington, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park Cemetery, Elkton, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>5-2-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4210 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		MARYLAND		STATE Maryland COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and give nearest town) Crestview		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Crestview			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4710 Bayard Blvd.				STREET ADDRESS (If rural give location) 4710 Bayard Blvd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Ernest (Middle) August (Last) Behrens				(Month) April (Day) 21 (Year) 1957			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 1/25/1889	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Behrens				14. MOTHER'S MAIDEN NAME Elsie D. Behrens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 4710 Bayard Blvd. Crestview, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Acute coronary thrombosis (myocardial infarction)				minutes			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) with coronary sclerosis				1 1/2 years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. He had an acute coronary thrombosis at the time first and I have treated him since then.				I saw him			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				I Talked to the coroner about this case and			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? he directed that I sign the certificate			
22. I hereby certify that I attended the deceased from Dec. 19, 1955 , to Feb. 27, 1957 , that I last saw the deceased alive on Feb. 27, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
SIGNATURE C. P. RYLAND		DATE SIGNED 4400- 49th St. N.W. Washington, D.C. 4-21-57					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/24/57		NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. REC'D BY REGISTRAR DR 24 1957		REGISTRAR'S SIGNATURE H. H. Hedrick		25. FUNERAL DIRECTOR'S SIGNATURE The S.M. Hines Co.			
DATE				ADDRESS 2901 14th St. NW Washington, D.C.			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

Date of Death

Place of Death

Age at Death

Sex

Color

Marital Status

Occupation

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

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Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

Age at Death

Sex

Color

Marital Status

Occupation

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

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Place of Birth

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Place of Birth

Date of Birth

Place of Birth

Usual Residence

Place of Birth

Date of Birth

Place of Birth

Usual Residence

ENCLOSURE

BUREAU V. 1

APR 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04152
2232

4170

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>6228 N. Dakota Ave. N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Emily</u> Last <u>Bell</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 11, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John W. Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Charles L. Zirkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Pts. daughter - same as above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3/23</u> , 19 <u>57</u> , to <u>4/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D.				ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash, D.C.</u>			
DATE SIGNED <u>4/14/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4/17/57</u>		<u>Greenwood Cemetery</u>		<u>Strasburg, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton H. Sager</u>				ADDRESS <u>Strasburg, Va</u>		24a. REC'D BY REGISTRAR <u>APR 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. M. Drell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Maryland

DATE OF DEATH: _____
PLACE OF DEATH: _____
AGE: _____
SEX: _____
RACE: _____
EDUCATION: _____
OCCUPATION: _____
MARRIAGE: _____
RELIGION: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF DECEASED: _____
SIGNATURE OF WITNESS: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF CORONER: _____
SIGNATURE OF JUDGE: _____
SIGNATURE OF CLERK: _____

RECEIVED
APR 22 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4211

CERTIFICATE OF DEATH

04183

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Bellows Last Bellows				4. DATE OF DEATH Month April Day 5 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/31/60	
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown Adams				14. MOTHER'S MAIDEN NAME Henrietta Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28 , 19 57 , to 4/5 , 19 57 , that I last saw the deceased alive on 4/4 , 19 57 , and that death occurred at 6:00 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird				ADDRESS (Street, city or town, state) Sandy Spring, Md.			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				DATE SIGNED Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surda				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR APR 9 1957	
				24b. REGISTRAR'S SIGNATURE Gertude Lawler			

04184

4212

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 10002 Summit Avenue	
3. NAME OF DECEASED (Type or print) William First W. Middle Bennett Last		4. DATE OF DEATH April 20 Day 19 Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/86
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 11 Days 12	IF UNDER 24 HRS. Hours 1 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY C & P Tel.Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gordan Bennett		14. MOTHER'S MAIDEN NAME Mary Elizabeth Henggi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-1996	
17. INFORMANT Olive Bennett		Address -- above Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) 1 yr INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 11, 1957 , to April 20, 1957 ; that I last saw the deceased alive on April 20, 1957 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sidney C Cousins M.D. 3921 Langdon St. N.W. #227 4/23/57			
ACTUAL SIGNATURE Sidney C Cousins			
PHYSICIAN'S NAME (Type) SIDNEY C COUSINS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/23/57	22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park. Cem.	22d. LOCATION (City, town, or county) (State) Falls Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 4-23-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

10000 Street Avenue

April 24

1957

10000 Street Avenue

10000 Street Avenue

10000 Street Avenue

10000 Street Avenue

10000 Street Avenue

10000 Street Avenue

BUREAU Y. L.

APR 24 1957

RECEIVED

4213

CERTIFICATE OF DEATH

Reg. Dist. No. 215

04185

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>Key West 48X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Kim</u> Middle <u>Warner</u> Last <u>BERGENHOLTZ</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 December 1955</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Raymond Warner Bergenholtz</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Ann Christiana (Same As #2)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Mother) Mrs. Josephine A. Bergenholtz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEUROBLASTOMA</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 April</u> 19 <u>57</u> , to <u>19 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>19 April 1957</u> , 19 _____, and that death occurred at <u>4:20A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel Shuptar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 4-20-57</u>			
PHYSICIAN'S NAME (Type) <u>DANIEL SHUPTAR, LT, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>				ADDRESS <u>1557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
DATE OF DEATH (Month, day, year)		TIME OF DEATH (Hour, minute)	
PLACE OF DEATH (City, State, Country)		CAUSE OF DEATH (List all causes, beginning with immediate cause)	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL HISTORY (List all diseases, injuries, operations, etc., in chronological order)	
OCCUPATION (At time of death)		EDUCATION (Highest grade completed)	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		RELIGION (If any)	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF WITNESSES (Two persons, one of whom shall be a physician)	
SIGNATURE OF PHYSICIAN (If death occurred in hospital or nursing home)		SIGNATURE OF CORONER (If death occurred elsewhere)	
CERTIFICATE NO. (Assigned by health department)		REGISTERED <input type="checkbox"/> Yes <input type="checkbox"/> No	

BUREAU V. 3

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04186

Reg. Dist. No. 214

4214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hosp.</u>		d. STREET ADDRESS <u>15217-ANDOVER Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HARRISON</u> Last <u>Bishop</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Jan. 11, 1900</u>	9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>	11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>
13. FATHER'S NAME <u>HARRISON SCOTT Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Rose McGovern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Int. del. Air Force</u>		16. SOCIAL SECURITY NO. <u>121-01-101000</u>	
17. INFORMANT <u>MRS. Viola Bishop</u>		Address <u>5217 Andover Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis Coronary Arteries</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>4-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Benjamin Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF EXAMINER		DATE		TIME	
HOSPITAL		PHYSICIAN		NURSE	
LABORATORY		PATHOLOGIST		TOPOGRAPHIC	
FORENSIC		TOXICOLOGICAL		BACTERIOLOGICAL	
ANTHROPOLOGICAL		DENTAL		RADIOLOGICAL	
PHYSIOLOGICAL		PSYCHOLOGICAL		SOCIOLOGICAL	
ECONOMICAL		LEGAL		POLITICAL	
CIVIL		MILITARY		MARITIME	
AERIAL		SPACE		OTHER	

RECEIVED
APR 15 1957
BUREAU V. S.

4215

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5202 Newport Ave.</u>		d. STREET ADDRESS <u>5202 Newport Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>BORREGARD</u> Last <u>BORREGARD</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4-1861</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Denmark</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>	
14. MOTHER'S MAIDEN NAME <u>Knudsen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>R. C. Borregard-5202 Newport Ave</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Undetermined many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>56</u> , to <u>April 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>57</u> , and that death occurred at <u>10:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron H. Traum</u>		DATE SIGNED <u>8237 Georgia Ave - Silver Spring Md 4/18/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>	22d. LOCATION (City, town, or county) (State) <u>300-4th NE D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		24. REC'D BY REGISTRAR <u>APR 23 1957</u>	
ADDRESS <u>300-4th NE</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04188

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 3813 Florence Drive			
3. NAME OF DECEASED (Type or print) First Maude Middle Zirkle Last Bowie				4. DATE OF DEATH Month April Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Claiborne Joseph Zirkle				14. MOTHER'S MAIDEN NAME Frances Elizabeth Hite			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Wm. Z. Bowie				Address 6455 Barnaby St. N.W., Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIAL NEPHROSCLEROSIS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington				(County)		(State)	
21. I certify that I attended the deceased from 25 April 1957 to 27 April 1957 , that I last saw the deceased alive on 27 April 1957 , and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Att. Richwine M.D.				ADDRESS (Street, city or town, state) 5522 Western Ave			
PHYSICIAN'S NAME (Type) Att. Richwine				DATE SIGNED 28 April 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Chamber Co.				ADDRESS 1400 Chapin St. N.W.		24a. REC'D BY REGISTRAR Beattie Thompson	
				DATE APR 30 1957			

CERTIFICATE OF DEATH

Form 100-104

RECEIVED
APR 30 1957
BUREAU V. 8

1. NAME OF DECEASED JOSE BALDWIN		2. SEX Male		3. AGE 18		4. DATE OF DEATH April 29, 1957		5. PLACE OF DEATH Home	
6. OCCUPATION Student		7. CAUSE OF DEATH Sudden		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.		10. DATE OF BIRTH April 11, 1939	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF NEXT OF KIN Mother		13. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		14. SIGNATURE OF REGISTRAR J. H. Smith		15. SIGNATURE OF CLERK J. H. Smith	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN Mother		18. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		19. SIGNATURE OF REGISTRAR J. H. Smith		20. SIGNATURE OF CLERK J. H. Smith	
21. SIGNATURE OF DECEASED (None)		22. SIGNATURE OF NEXT OF KIN Mother		23. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		24. SIGNATURE OF REGISTRAR J. H. Smith		25. SIGNATURE OF CLERK J. H. Smith	
26. SIGNATURE OF DECEASED (None)		27. SIGNATURE OF NEXT OF KIN Mother		28. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		29. SIGNATURE OF REGISTRAR J. H. Smith		30. SIGNATURE OF CLERK J. H. Smith	
31. SIGNATURE OF DECEASED (None)		32. SIGNATURE OF NEXT OF KIN Mother		33. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		34. SIGNATURE OF REGISTRAR J. H. Smith		35. SIGNATURE OF CLERK J. H. Smith	
36. SIGNATURE OF DECEASED (None)		37. SIGNATURE OF NEXT OF KIN Mother		38. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		39. SIGNATURE OF REGISTRAR J. H. Smith		40. SIGNATURE OF CLERK J. H. Smith	
41. SIGNATURE OF DECEASED (None)		42. SIGNATURE OF NEXT OF KIN Mother		43. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		44. SIGNATURE OF REGISTRAR J. H. Smith		45. SIGNATURE OF CLERK J. H. Smith	
46. SIGNATURE OF DECEASED (None)		47. SIGNATURE OF NEXT OF KIN Mother		48. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		49. SIGNATURE OF REGISTRAR J. H. Smith		50. SIGNATURE OF CLERK J. H. Smith	
51. SIGNATURE OF DECEASED (None)		52. SIGNATURE OF NEXT OF KIN Mother		53. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		54. SIGNATURE OF REGISTRAR J. H. Smith		55. SIGNATURE OF CLERK J. H. Smith	
56. SIGNATURE OF DECEASED (None)		57. SIGNATURE OF NEXT OF KIN Mother		58. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		59. SIGNATURE OF REGISTRAR J. H. Smith		60. SIGNATURE OF CLERK J. H. Smith	
61. SIGNATURE OF DECEASED (None)		62. SIGNATURE OF NEXT OF KIN Mother		63. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		64. SIGNATURE OF REGISTRAR J. H. Smith		65. SIGNATURE OF CLERK J. H. Smith	
66. SIGNATURE OF DECEASED (None)		67. SIGNATURE OF NEXT OF KIN Mother		68. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		69. SIGNATURE OF REGISTRAR J. H. Smith		70. SIGNATURE OF CLERK J. H. Smith	
71. SIGNATURE OF DECEASED (None)		72. SIGNATURE OF NEXT OF KIN Mother		73. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		74. SIGNATURE OF REGISTRAR J. H. Smith		75. SIGNATURE OF CLERK J. H. Smith	
76. SIGNATURE OF DECEASED (None)		77. SIGNATURE OF NEXT OF KIN Mother		78. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		79. SIGNATURE OF REGISTRAR J. H. Smith		80. SIGNATURE OF CLERK J. H. Smith	
81. SIGNATURE OF DECEASED (None)		82. SIGNATURE OF NEXT OF KIN Mother		83. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		84. SIGNATURE OF REGISTRAR J. H. Smith		85. SIGNATURE OF CLERK J. H. Smith	
86. SIGNATURE OF DECEASED (None)		87. SIGNATURE OF NEXT OF KIN Mother		88. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		89. SIGNATURE OF REGISTRAR J. H. Smith		90. SIGNATURE OF CLERK J. H. Smith	
91. SIGNATURE OF DECEASED (None)		92. SIGNATURE OF NEXT OF KIN Mother		93. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		94. SIGNATURE OF REGISTRAR J. H. Smith		95. SIGNATURE OF CLERK J. H. Smith	
96. SIGNATURE OF DECEASED (None)		97. SIGNATURE OF NEXT OF KIN Mother		98. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		99. SIGNATURE OF REGISTRAR J. H. Smith		100. SIGNATURE OF CLERK J. H. Smith	

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 49 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 211 "E" St., N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Shields Middle King Last BOWLES		4. DATE OF DEATH Month April Day 29 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 August 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (Civil Service)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hal Bowles				14. MOTHER'S MAIDEN NAME Florence Branham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 7-6-17 to 5-9-19		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Mrs. Mabel Hunter Bowles (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197X DUE TO Asplenia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma invading and occluding DUE TO inferior vena cava and renal veins. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 wks 3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 March , 19 57 , to 29 April , 19 57 , that I last saw the deceased alive on 29 April , 19 57 , and that death occurred at 1:16 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 4-30-57							
ACTUAL SIGNATURE J. S. Horgan				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J. T. HORGAN, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS 4th & Mass Ave., Wash. D. C.		24a. REC'D BY REGISTRAR 4-30-57	
				24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 8

MAY 1 1957

4218

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 6 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3214 Fayette Road				d. STREET ADDRESS 3214 Fayette Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IDA Middle E. Last BOYD				4. DATE OF DEATH Month APRIL Day 24 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/86	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk				10b. KIND OF BUSINESS OR INDUSTRY Publishing Co.		11. BIRTHPLACE (State or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FREDERICK BREY				14. MOTHER'S MAIDEN NAME ADOLPHINE GIESSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-20-5811A		17. INFORMANT Address Mrs. Eileen Pfreundschuh, 3214 Fayette Road Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism (acute) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of lower leg DUE TO Carcinoma - of Breast (Radical Resection Feb '57) (c) Adenoma - Thyroid Resected Feb '57 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Feb 15, 1957 Carcinoma of Breast - Radical Resection INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs 1 week							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1954 , 19____, to 4/23 , 19 57 , that I last saw the deceased alive on 4/23/57 , 19____, and that death occurred at 2A M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Kensington, Md. 4/24/57							
ACTUAL SIGNATURE Samuel Allen M.D.				PHYSICIAN'S NAME (Type) Samuel Allen, Kensington, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
TRANS. & BURIAL		4/27/57		FRESH POND CEMETERY		MIDDLE VILLAGE, NEW YORK COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/25/57	
24b. REGISTRAR'S SIGNATURE Frances [Signature]							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HENRY		2. SEX Male		3. AGE 45		4. DATE OF BIRTH JAN 15 1912		5. PLACE OF BIRTH NEW YORK CITY	
6. OCCUPATION Clerk		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. TIME OF DEATH 10:30 AM	
11. SIGNATURE OF DECEASED James J. Henry		12. SIGNATURE OF WITNESS John Doe		13. SIGNATURE OF PHYSICIAN Dr. Smith		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF REGISTRAR John Doe	
16. NAME OF FUNERAL HOME John Doe		17. NAME OF BURIAL PLACE St. John's Church		18. NAME OF CEMETERY St. John's Cemetery		19. NAME OF INTERMENT St. John's Interment		20. NAME OF CREMATION St. John's Cremation	
21. NAME OF NEXT OF KIN John Doe		22. NAME OF SURVIVOR John Doe		23. NAME OF SURVIVOR John Doe		24. NAME OF SURVIVOR John Doe		25. NAME OF SURVIVOR John Doe	
26. NAME OF SURVIVOR John Doe		27. NAME OF SURVIVOR John Doe		28. NAME OF SURVIVOR John Doe		29. NAME OF SURVIVOR John Doe		30. NAME OF SURVIVOR John Doe	
31. NAME OF SURVIVOR John Doe		32. NAME OF SURVIVOR John Doe		33. NAME OF SURVIVOR John Doe		34. NAME OF SURVIVOR John Doe		35. NAME OF SURVIVOR John Doe	
36. NAME OF SURVIVOR John Doe		37. NAME OF SURVIVOR John Doe		38. NAME OF SURVIVOR John Doe		39. NAME OF SURVIVOR John Doe		40. NAME OF SURVIVOR John Doe	
41. NAME OF SURVIVOR John Doe		42. NAME OF SURVIVOR John Doe		43. NAME OF SURVIVOR John Doe		44. NAME OF SURVIVOR John Doe		45. NAME OF SURVIVOR John Doe	
46. NAME OF SURVIVOR John Doe		47. NAME OF SURVIVOR John Doe		48. NAME OF SURVIVOR John Doe		49. NAME OF SURVIVOR John Doe		50. NAME OF SURVIVOR John Doe	
51. NAME OF SURVIVOR John Doe		52. NAME OF SURVIVOR John Doe		53. NAME OF SURVIVOR John Doe		54. NAME OF SURVIVOR John Doe		55. NAME OF SURVIVOR John Doe	
56. NAME OF SURVIVOR John Doe		57. NAME OF SURVIVOR John Doe		58. NAME OF SURVIVOR John Doe		59. NAME OF SURVIVOR John Doe		60. NAME OF SURVIVOR John Doe	
61. NAME OF SURVIVOR John Doe		62. NAME OF SURVIVOR John Doe		63. NAME OF SURVIVOR John Doe		64. NAME OF SURVIVOR John Doe		65. NAME OF SURVIVOR John Doe	
66. NAME OF SURVIVOR John Doe		67. NAME OF SURVIVOR John Doe		68. NAME OF SURVIVOR John Doe		69. NAME OF SURVIVOR John Doe		70. NAME OF SURVIVOR John Doe	
71. NAME OF SURVIVOR John Doe		72. NAME OF SURVIVOR John Doe		73. NAME OF SURVIVOR John Doe		74. NAME OF SURVIVOR John Doe		75. NAME OF SURVIVOR John Doe	
76. NAME OF SURVIVOR John Doe		77. NAME OF SURVIVOR John Doe		78. NAME OF SURVIVOR John Doe		79. NAME OF SURVIVOR John Doe		80. NAME OF SURVIVOR John Doe	
81. NAME OF SURVIVOR John Doe		82. NAME OF SURVIVOR John Doe		83. NAME OF SURVIVOR John Doe		84. NAME OF SURVIVOR John Doe		85. NAME OF SURVIVOR John Doe	
86. NAME OF SURVIVOR John Doe		87. NAME OF SURVIVOR John Doe		88. NAME OF SURVIVOR John Doe		89. NAME OF SURVIVOR John Doe		90. NAME OF SURVIVOR John Doe	
91. NAME OF SURVIVOR John Doe		92. NAME OF SURVIVOR John Doe		93. NAME OF SURVIVOR John Doe		94. NAME OF SURVIVOR John Doe		95. NAME OF SURVIVOR John Doe	
96. NAME OF SURVIVOR John Doe		97. NAME OF SURVIVOR John Doe		98. NAME OF SURVIVOR John Doe		99. NAME OF SURVIVOR John Doe		100. NAME OF SURVIVOR John Doe	

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

CERTIFICATE OF DEATH

Reg. Dist. No. 24

041914

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8633 - 11th AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BARBARA ELALIEU BRANDE				4. DATE OF DEATH Month Day Year APRIL 15 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1936	9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY -- FEDERAL		10b. KIND OF BUSINESS OR INDUSTRY RESERVE BOARD		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM REID BRANDE				14. MOTHER'S MAIDEN NAME ORETA AUSTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-46-2223		17. INFORMANT Address MRS. WM. REID BRANDE, 8633 - 11th AVE., SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGENITAL HEART 754.4 DUE TO ABNORMALITY - STRESS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE PAROXYSMAL TACHYCARDIA DUE TO (c) ACUTE PAROXYSMAL TACHYCARDIA						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from August 19 56 to April 15 19 57 , that I last saw the deceased alive on April 15 19 57 , and that death occurred at 7:06 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Quinn		M.D. 501 - 8 South Hampton Drive		DATE SIGNED			
PHYSICIAN'S NAME (Type) THOMAS F. QUINN M.D.		SILVER SPRING, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/17/57	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Wanner B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/18/57	24b. REGISTRAR'S SIGNATURE Frances Potter		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	

BUREAU V. 3

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04192

4220

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>R.F.D. Monrovia</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>E.</u> Last <u>Burdette</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Layton</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Warfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Roger F. Burdette, College Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroselective cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 15, 1954</u> , to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u> M.D.				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Molesworth</u> ADDRESS <u>Damascus, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Apr. 9/57</u>		24b. REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>	

772 2003-2004

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. 3

APR 10 1957

RECEIVED

4221

CERTIFICATE OF DEATH

04193214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING				d. STREET ADDRESS 11,300 GALT AVENUE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,300 GALT AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle CALIGURI Last CALIGURI				4. DATE OF DEATH Month APRIL Day 14 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 21, 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER - U. S. Capital				10b. KIND OF BUSINESS OR INDUSTRY ITALY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ANTHONY CALIGURI				14. MOTHER'S MAIDEN NAME JENNIE CALIGURI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 579-07-7144			
17. INFORMANT Mr. Albert Fiorentino, 11,300 Galt Ave.				Address Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 1 day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis, Generalized DUE TO years (c) 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1, 1957 to April 14, 1957 that I last saw the deceased alive on April 14, 1957 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave DATE SIGNED 4/17/57							
ACTUAL SIGNATURE John J. Curry M.D.							
PHYSICIAN'S NAME (Type) JOHN J. CURRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 4/18/57							
22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY							
22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Humphrey ADDRESS SILVER SPRING, MD.							
24a. REC'D BY REGISTRAR DATE 4/18/57							
24b. REGISTRAR'S SIGNATURE Frances Potter							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
NAME		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
MILITARY SERVICE		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. S.

APR 22 1957

RECEIVED

4222

CERTIFICATE OF DEATH

Reg. Dist. No.

04194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>72 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>11 Armor Green S.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Ann</u> Last <u>CAPECI</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 April 1957</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Robert Lee Capeci</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Frances Boerner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>(Father) Robert L. Capeci (Same As #2)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL ATELECTASIS</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 Hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>20 April</u> 19 <u>57</u> , to <u>23 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>23 April</u> 19 <u>57</u> , and that death occurred at <u>3:08A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Daniel Shuptar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-23-57</u> PHYSICIAN'S NAME (Type) <u>Daniel Shuptar, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>26 Apr. 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>1551 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bray & Casella</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2151242XV2

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause of death, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED
APR 24 1957
BUREAU V. A.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4223
CERTIFICATE OF DEATH

04195
274

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2200 DENNIS AVENUE				d. STREET ADDRESS 1 2200 DENNIS AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MIDDLE Last NANNIE MAE CARMER				4. DATE OF DEATH Month Day Year APRIL 3 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/74	
9. AGE (In years less birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown LOCKHART				14. MOTHER'S MAIDEN NAME CATHERINE BOOTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Tyree B. Cunningham, 2200 Dennis Avenue Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage 1 Day Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420 Arteriosclerotic Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1952 to April 3 1957 that I last saw the deceased alive on April 3 1957, and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John J. Curry M.D. 10620 Georgia Ave Silver Spring, Md 4/4/57							
PHYSICIAN'S NAME (Type) JOHN J. CURRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey, SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE Francis Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: <i>Coretta Scott King</i>]</p>		<p>2. SEX [Handwritten: <i>F</i>]</p>	
<p>3. AGE [Handwritten: <i>39</i>]</p>		<p>4. DATE OF BIRTH [Handwritten: <i>1-15-28</i>]</p>	
<p>5. PLACE OF BIRTH [Handwritten: <i>Indianapolis, Ind.</i>]</p>		<p>6. OCCUPATION [Handwritten: <i>Minister</i>]</p>	
<p>7. MARITAL STATUS [Handwritten: <i>Married</i>]</p>		<p>8. DATE OF MARRIAGE [Handwritten: <i>1-15-56</i>]</p>	
<p>9. NAME OF SPOUSE [Handwritten: <i>Dr. Martin Luther King, Jr.</i>]</p>		<p>10. DATE OF DEATH [Handwritten: <i>4-4-68</i>]</p>	
<p>11. PLACE OF DEATH [Handwritten: <i>Memphis, Tenn.</i>]</p>		<p>12. CAUSE OF DEATH [Handwritten: <i>Assault with a Dangerous Weapon</i>]</p>	
<p>13. MANNER OF DEATH [Handwritten: <i>Homicide</i>]</p>		<p>14. SIGNATURE OF PHYSICIAN [Handwritten: <i>Dr. J. Edgar Hoover</i>]</p>	
<p>15. SIGNATURE OF CORONER [Handwritten: <i>Dr. J. Edgar Hoover</i>]</p>		<p>16. SIGNATURE OF DEATH REGISTRAR [Handwritten: <i>Dr. J. Edgar Hoover</i>]</p>	

BUREAU V. S.

APR 10 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4224 CERTIFICATE OF DEATH

04196

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens</u>				d. STREET ADDRESS <u>3921 Military Road N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>KUHN</u> Middle <u>CARSTENS</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-23-68</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FREDERICK MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>KUHN</u>				14. MOTHER'S MAIDEN NAME <u>FRAILEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____			
17. INFORMANT <u>Hospital Records</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure, acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, advanced</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>1094</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinomatosis of abdomen</u> (b) <u>Fractured left hip (Jan 17, 1957)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. _____ 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 2, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingomar St. N.W.</u> DATE SIGNED <u>4.2.57</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				<u>Wash 15 D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company,</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>4/19/57</u> 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4225

CERTIFICATE OF DEATH

Reg. Dist. No.

04197

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 8 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 808 WAYNE AVENUE		d. STREET ADDRESS 808 WAYNE AVENUE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DAVID Middle ELDER Last CATHRO		4. DATE OF DEATH Month APRIL Day 4 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 5, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT	11. BIRTHPLACE (State or foreign country) DUNDEE, SCOTLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM CATHRO		14. MOTHER'S MAIDEN NAME JEAN HARRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW # 1		16. SOCIAL SECURITY NO. 034-07-1759	
17. INFORMANT Mrs. Sybella M. Cathro, 808 Wayne Ave.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery occlusion DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 minutes 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from NOV. 1953 , to APR. 4, 1957 , that I last saw the deceased alive on APR. 4, 1957 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 929 Pershing Drive, Silver Spring, Md. ACTUAL SIGNATURE Saruch T. Kimble M.D. Francis J. P. [Signature] PHYSICIAN'S NAME (Type) SARUCH T. KIMBLE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/8/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY
22d. LOCATION (City, town, or county)		(State)	
ARLINGTON, VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 4/8/57		24b. REGISTRAR'S SIGNATURE Francis J. P. [Signature]	

MARTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

4171

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairhill Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie D. Clarke</u>				4. DATE OF DEATH Month Day Year <u>April 8 1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George F Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hallie F White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Norton Clarke (son) As Deceased's</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, Generalized</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 6</u> , 19 <u>57</u> , to <u>April 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>57</u> , and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u>		DATE SIGNED <u>Apr. 8, 57</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>				<u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>Wash, DC</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED	
APR 11 1957	
BUREAU V. S.	

BUREAU V. S.

APR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4226

CERTIFICATE OF DEATH

Reg. Dist. No.

04199

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Grafton St., C. C., Md.</u>		d. STREET ADDRESS <u>125 Grafton St.</u>	
3. NAME OF DECEASED (Type or print) <u>Sara</u> First <u>Guy</u> Middle <u>Colclough</u> Last		4. DATE OF DEATH <u>April 23</u> Month <u>23</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1877</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Stamandale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Robert H. Guy</u>		14. MOTHER'S MAIDEN NAME <u>Sara Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Oswald Colclough</u> Address <u>Ch. C., Md. 25 Grafton St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 7, 1957</u> to <u>April 23, 1957</u> that I last saw the deceased alive on <u>April 20, 1957</u> and that death occurred at <u>5 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.		ADDRESS (Street, city or town, state) <u>4861 A Battery Lane Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		DATE SIGNED <u>4/23/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 26, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph S. Smith</u> ADDRESS <u>1750 Pennsylvania Ave NW, Washington, DC</u>		24a. REC'D BY REGISTRAR <u>DATE 4-25-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

BUREAU V. S.

APR 29 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 1/2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 2504 Sheraton St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle Mae Last Cole				4. DATE OF DEATH Month April Day 6 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1922		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis William Miller				14. MOTHER'S MAIDEN NAME Nellie Legeer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hannibal Cole		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arsenic poisoning - suicide 971.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have drank some weed killer					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION Phil		22b. DATE THEREOF 57		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE ROY W. BARBER LAYTONSVILLE MD				24a. REC'D BY REGISTRAR DATE 4-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
DEPARTMENT OF HEALTH - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Last Name		First Name		Middle Name	
Miller		John		David		Lester	
Date of Birth		Place of Birth		Sex		Race	
1901		Texas		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
1957		Texas		Heart Disease		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

APR 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04201
214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, 26</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Manor Shopping Center, University Blvd..</u>				d. STREET ADDRESS <u>12,706 Turkey Branch Pkwy</u>			
3. NAME OF DECEASED (Type or print) First <u>Gloria</u> Middle <u>C</u> Last <u>Conner</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/26</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RAYMOND CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>THELMA WOODS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Mr. Charles B. Conner, 12,706 Turkey Br. Pkwy. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>830x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of facial bones</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by own car which was drifting backwards</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:25</u> <u>Apr. 8</u> <u>1957</u> Hour <u>7:25</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Shopping Center in Wheaton, Montgomery, Maryland</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>April 8, 1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>4/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis P. Little</u>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Toxicology		Other Findings	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	

BUREAU V. 2

APR 17 1957

RECEIVED

4229

CERTIFICATE OF DEATH

04202

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY James City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amie Middle Lee Last Cook				4. DATE OF DEATH Month April Day 25 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1935	
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.		IF UNDER 24 HRS. Months 21 Days 21 Hours 21 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Waitress Work		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Devaney Conner				14. MOTHER'S MAIDEN NAME Helen Stringfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion and edema 710.0 DUE TO							Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Generalized scleroderma with DUE TO							
(c) myocardial fibrosis							Months (8)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from April 22, 1957 , to April 25, 1957 , that I last saw the deceased alive on April 25, 1957 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel D. Federman				DATE SIGNED 4/25/57			
PHYSICIAN'S NAME (Type) DANIEL D. FEDERMAN, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Williamsburg Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Fagier's Funeral Home Inc. - 389 R. Ave. NW				24a. REC'D BY REGISTRAR APR 29 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

James City

Virginia

Montgomery

William W.

1 day

Montgomery, Ala.

607 Commonwealth Street

The Clinical Center, Bethesda, Md.

April 1

Good

Two

Male

June 1, 1907

Montgomery, Ala.

Montgomery

Montgomery, Ala.

Montgomery, Ala.

John S. S. S.

John S. S. S.

The Clinical Center

Montgomery

Montgomery

BUREAU V. 1

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4172

CERTIFICATE OF DEATH

Reg. Dist. No. 04208-3

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>3060 16th St N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Hancock</u> Last <u>COOK</u>			4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>George P Bohrer</u>			14. MOTHER'S MAIDEN NAME <u>Eva Hancock</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarct of myocardium, left ventricle</u> DUE TO (c) <u>Occlusion of coronary arteries (arteriosclerosis)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, marked</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-16</u> , 19 <u>56</u> , to <u>4-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>57</u> , and that death occurred at <u>10:44</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H. Volohn</u>				M.D. <u>500 Underwood Street, N.W.</u>			
PHYSICIAN'S NAME (Type) <u>Chas H. Volohn</u>				Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. DC</u>				24a. REC'D BY REGISTRAR <u>MAY 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAY 1 1957

RECEIVED

4230

CERTIFICATE OF DEATH

Reg. Dist. No. 042046

1. PLACE OF DEATH a. COUNTY Montgomery, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mr. Benjamin Raymond Cooley				4. DATE OF DEATH Month April Day 20 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Min. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Richard Edward Cooley				14. MOTHER'S MAIDEN NAME Louise Auston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Richard E. Cooley				Address 5318 Belt Rd., N.W. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Corrupt Heart Failure						1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Edema						3 wks	
(c) Branchogenic Carcinoma						6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1 April, 1957 to 20 April, 1957 , that I last saw the deceased alive on 19 April, 1957 , and that death occurred at 11:34 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Merton L. White				M.D. 11/34 Georgia Ave S.S. Md.			
PHYSICIAN'S NAME (Type) Merton L. White				11134 Georgia Ave. S.S. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4/24/57		St. Mary's		Barnesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 4-22-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU 1

BUREAU V. 1

APR 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4231

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 15X22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4404 Montgomery Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>LEE</u> First <u>CRANDALL, sr</u> Middle Last				4. DATE OF DEATH <u>4-15-57</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-77</u>	9. AGE (In years last birthday) <u>80 1/2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Crandall</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Giers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-34-3251A</u>		17. INFORMANT <u>Harriet Y. Crandall-Item# 2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Arteriosclerosis and Lung Efficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> (c) <u>Neurovascular, Bilateral</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>December, 1956</u> to <u>15 April, 1957</u> , that I last saw the deceased alive on <u>13 April, 1957</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Homer L. Reighard</u>		M.D. <u>6114 WASHINGTON RD.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>4/15/57</u>	
PHYSICIAN'S NAME (Type) <u>HOMER L. REIGHARD, M.D.</u>		<u>WASHINGTON 16 D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Suitland, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>4-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beanie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4231

APR 17 1957

BUREAU V. S.

RECEIVED

4232

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oregon b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1880 Southwest Eleventh Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Francis George Daggett				4. DATE OF DEATH Month Day Year April 23, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 24, 1914	
9. AGE (In years lost by day) yrs. 42		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Daggett				14. MOTHER'S MAIDEN NAME Katherine Pearce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 024-03-4779		17. INFORMANT The Medical Record address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation at Surgery 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Fever - Aortic Stenosis Several years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 3, 1957 , to April 23, 1957 , that I last saw the deceased alive on April 23, 1957 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard J. Sanders M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 4/23/57							
PHYSICIAN'S NAME (Type) RICHARD J. SANDERS, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4/25/57		—		Portland, Oregon	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS Wash., D.C.		24a. REC'D BY REGISTRAR DATE APR 25 57	
24b. REGISTRAR'S SIGNATURE Al. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

APR 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4233

CERTIFICATE OF DEATH

Reg. Dist. No. 216

04207

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 140 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Viola Last Dawson				4. DATE OF DEATH Month April Day 29 , Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 22, 1902	
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		11. IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist				10b. KIND OF BUSINESS OR INDUSTRY unknown			
11. BIRTHPLACE (State or foreign country) Iowa				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William J. Williams				14. MOTHER'S MAIDEN NAME May Andrews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT The Medical Record				18. ADDRESS The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma DUE TO (c) Carcinoma of Breast INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 10, 1956 , to April 29, 1957 , that I last saw the deceased alive on April 29, 1957 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE William J. Pieper				DATE SIGNED 4/30/57			
PHYSICIAN'S NAME (Type) William J. Pieper, M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.K. Huntemann & Son				24a. REC'D BY REGISTRAR 5-2-57			
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

State of Colorado

County of _____

City of _____

Dec 1957

The Clinical Center, Denver, Colorado

Department of _____

December 22, 1957

Unknown

Unknown

1, 1957

The Clinical Center, Denver, Colorado

BUREAU V. 7

MAY 6 1957

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See: Birth Cert.

04208

4173

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Simpsonville 13 X 02</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>16 Dillwood Drive</i>	
3. NAME OF DECEASED (Type or print) First <i>Baby Girl</i> Middle <i>Dolezal</i> Last <i>Dolezal</i>		4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/24/57</i>
9. AGE (In years last birthday) yrs. <i>1</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>38</i> Hours <i>10</i> Min <i>10</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Luke Victor Dolezal</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude May George</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>prematurity</i> DUE TO (c) <i>prematurity</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-24-57</i> , 19 <i>57</i> , to <i>4-26</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4-26-57</i> , 19 <i>57</i> , and that death occurred at <i>12:50 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Ruth Standard</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Ruth Standard, M. D. Washington San. & Hosp. Takoma Park, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>4-26-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium & Hosp. Takoma Park, Maryland</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M. D. Wash. San. & Hosp.</i>		24a. REC'D BY REGISTRAR <i>APR 30 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>John L. Ladd</i>			

2075 323XVV Takoma Park, Md.

MAY 1 1957

RECEIVED

4234

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Mountgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>17</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San + Hosp</u>				d. STREET ADDRESS <u>6821 Eastern Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Madge</u> Middle <u>C</u> Last <u>Douglas</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byron C. Coon</u>				14. MOTHER'S MAIDEN NAME <u>Janet McPherson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Willard R. Douglas, (same as #2)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" arteriosclerosis</u> DUE TO (c) <u>Korsakoff's Syndrome</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr. 18, 1957</u> , to <u>April 24, 1957</u> , that I last saw the deceased alive on <u>April 24, 1957</u> , and that death occurred at <u>7:35 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Thibadeau</u>				M.D. <u>Columbia Rd. Silver Spring, Md.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>4/24/57</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD-B. THIBADEAU.</u>				" " <u>Sil. Sp.</u> <u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wallers</u>				ADDRESS <u>254 Carroll St NW</u>			
24a. REC'D BY REGISTRAR <u>APR 29 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		MARRIAGE	
JAMES J. JONES		M		35		JAN 15 1922		NEW YORK		MARRIED	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		APR 10 1957		HOSPITAL	
FATHER		MOTHER		BORN		DIED		BURIED		INTERMENT	
JAMES J. JONES		MARY J. JONES		JAN 15 1922		APR 10 1957		CATHOLIC		ST. MARY'S CHURCH	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
APR 10 1957		J. J. JONES		JAMES J. JONES		MARY J. JONES		J. J. JONES		J. J. JONES	

RECEIVED
APR 29 1957
BUREAU V. R.

4235

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring,</u>				c. LENGTH OF STAY IN 1b <u>56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San. & Hosp</u>				d. STREET ADDRESS <u>508 Thayer</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Emily W. Dowling</u>				4. DATE OF DEATH <u>(12:10) Noon April 21 1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1914</u>	9. AGE (In years last birthday) yrs. <u>42</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>FRIEND P. WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>ALMA HORTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Husband 508 Thayer, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis</u> <u>317.5</u> DUE TO <u>an</u> <u>anition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>Psychoneurotic Reaction</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>57</u> , to <u>4-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>57</u> , and that death occurred at <u>12:10</u> <u>noon</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cedarcroft San. & Hosp. R#2 St. Spg. Md</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Alvin J. Kistler</u> M.D.				PHYSICIAN'S NAME (Type) <u>Alvin J. Kistler, House Physician</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN GROVE CEM. BRIDGEPORT</u>		22d. LOCATION (City, town, or county) (State) <u>CONN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walker</u>				24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF BIRTH [Faint text]</p>		<p>6. PLACE OF BIRTH [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

1957

RECEIVED

APR 23 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

223

4174

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Washington 16</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>14811 Westway Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertna</u> Middle <u>Tompkins</u> Last <u>DYSON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-80</u>	
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept. of Agriculture</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
13. FATHER'S NAME <u>Horace Tompkins</u>				14. MOTHER'S MAIDEN NAME <u>Jeannette Stillwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Wash. San. & Hosp. Records</u>				Address <u>Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial heart disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>20 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>1953</u> , 19 <u> </u> to <u>Apr 25</u> , 19 <u>37</u> that I last saw the deceased alive on <u>4/24</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 UNDERWOOD STREET N.W.</u> DATE SIGNED <u>4/25/57</u>							
ACTUAL SIGNATURE <u>Chas H W. Lohman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Chas H W. Lohman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-29-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Canters</u>				24. REG'D BY REGISTRAR <u>APR 30 1957</u>			
ADDRESS <u>1756 Pa. Ave. N.W.</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4236

CERTIFICATE OF DEATH

Reg. Dist. No.

04212

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lawrence Edward Emge				4. DATE OF DEATH April 17 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/07	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Specialist - Veterans Adm. U.S. Gov't				11. BIRTHPLACE (State or foreign country) District of Columbia			
13. FATHER'S NAME Joseph Edward Emge				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. #2				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Lilly Emge				Address as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Ventricular fibrillation DUE TO acute posterior infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary-arteriosclerotic heart disease 4 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 34 , 19, to 4/17/57 , 19, that I last saw the deceased alive on 4/17/57 , 19, and that death occurred at 6:35 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Bernard J. Walsh M.D.				900-17th St. S.W. - 4/17/57			
PHYSICIAN'S NAME (Type) BERNARD J. WALSH							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/22/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-22-57	
				24b. REGISTRAR'S SIGNATURE Bernard J. Walsh			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 24 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4237

CERTIFICATE OF DEATH

04213

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clagettsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clagettsville	
c. LENGTH OF STAY IN 1b 15 Years		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) C ^{First} h ^{Middle} a ^{Last} r l e s w i l e r		4. DATE OF DEATH April ^{Month} II ^{Day} 19 ^{Year} 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Emswiler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alice Emswiler		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior ischemic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 30 , 19 49 to April 11 , 19 57 , that I last saw the deceased alive on April 8 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Ind. DATE SIGNED 4/11/57			
ACTUAL SIGNATURE James P. Kerr M.D.		PHYSICIAN'S NAME (Type) James P. Kerr Damascus, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 13 1957	22c. NAME OF CEMETERY OR CREMATORY Flower Hill	22d. LOCATION (City, town, or county) Redland (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber		24a. REC'D BY REGISTRAR DATE April 17/57	
ADDRESS Laytonsville, Md.		24b. REGISTRAR'S SIGNATURE Della W. Burdette	

BUREAU

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4238

CERTIFICATE OF DEATH

04214

214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Fleetwood Street				d. STREET ADDRESS 504 Fleetwood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CAROL Middle LUCILLE Last ENOS				4. DATE OF DEATH Month April Day 10th Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21st, 1944		9. AGE (In years lost birthday) yrs. 12	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grade school		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Linwood E. Enos				14. MOTHER'S MAIDEN NAME Carrie A. Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Silver Spring, Md. Linwood E. Enos, 504 Fleetwood St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation - vomitus. 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Upper respiratory infection DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH Acute 24 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAR , 19 57 , to April 10 , 19 57 , that I last saw the deceased alive on April 10 , 19 57 , and that death occurred at 9:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest C. Sarao				M.D. 7006 New Hampshire Ave		DATE SIGNED April 19 1957	
PHYSICIAN'S NAME (Type) Ernest C. Sarao				ADDRESS (Street, city or town, state) Takoma Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pe. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				ADDRESS 		24a. REC'D BY REGISTRAR APR 15 1957	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

BUREAU V. S.

APR 15 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04215

4285 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTG.			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westmoreland Hills		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westmoreland Hills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5138 MASS. AVE.				STREET ADDRESS (If rural give location) 5138 MASS. AVE.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ANDREW (Middle) BROWN E (Last) EVANS				(Month) APRIL (Day) 23 (Year) 1957			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 5/4/88	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Own practice		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Evans				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. John W. Robinson 9313 Adeline Dr. Bethesda, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Acute coronary thrombosis (myocardial infarction) minutes							
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) He had a myocardial infarction about 10 years ago, has been under care of Dr. Paul Lichtman, a cardiologist since then, saw him about 3 mo. ago. I was called							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. He had a myocardial infarction about 10 years ago, has been under care of Dr. Paul Lichtman, a cardiologist since then, saw him about 3 mo. ago. I was called							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION The Coroner told me to sign the certificate		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 1957....., and that death occurred at....., 11:45 PM, from the causes and on the date stated above.							
SIGNATURE C. P. Ryland				ADDRESS (Street, city, town, state) DATE SIGNED			
C.P. RYLAND M.D. 4400 - 49th St. N.W. Washington, D.C. 4-24-57							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 4/26/57		NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince George County, Md.	
24. REC'D BY REGISTRAR DATE 4/20/57		REGISTRAR'S SIGNATURE Shary Parrelly		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.		ADDRESS	

CERTIFICATE OF DEATH

Page 1 of 2

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
MARRIAGE: [illegible]
OCCUPATION: [illegible]

CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
HOURS OF DEATH: [illegible]

PHYSICIAN: [illegible]
NATURAL CAUSE OF DEATH: [illegible]
UNNATURAL CAUSE OF DEATH: [illegible]

Also reported to the Bureau of Health Statistics, Massachusetts Department of Health, Boston, Massachusetts, on [illegible] day of [illegible] 1957.

BUREAU V. 81

APR 27 1957

RECEIVED

4240

CERTIFICATE OF DEATH

Reg. Dist. No.

04216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day, 15 hr's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle Gertrude Last Evans		4. DATE OF DEATH Month April Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1874
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 83 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Shreve		14. MOTHER'S MAIDEN NAME Caroline Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Stephen H. Evans		Address Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Hemorrhage. DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis. DUE TO (c) 104 yr.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Apr 57 to 27 Apr 1957 , that I last saw the deceased alive on 26 Apr 1957 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. H. Richwine M.D.		ADDRESS (Street, city or town, state) 5522 Western Ave	
PHYSICIAN'S NAME (Type) A. H. RICHWINE		DATE SIGNED 27 Apr 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. RECEIVED BY REGISTRAR APR 28 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

4241 Item 2 Film 0214 4-29-57 et
Item 9 Film 0214 5-3-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04218

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1 Unknown</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ALBERT A FAIRALL</i> First Middle Last		4. DATE OF DEATH <i>April 25 1957</i> Month Day Year	
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-68</i> 89 yrs.
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Tenn. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Owens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>181X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>metastatic carcinoma</i> DUE TO (c) <i>carcinoma of bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hr.</i> <i>6 mo.</i> <i>1 1/2 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1955</i> to <i>4-25-57</i> that I last saw the deceased alive on <i>4-23-57</i> , and that death occurred on <i>12 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John Rogers</i> M.D.		DATE SIGNED <i>4-25-57</i>	
PHYSICIAN'S NAME (Type) <i>John Rogers</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>4-27-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Calverton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - D.C.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>4/26/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Francis Potter</i>	

W

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4175

CERTIFICATE OF DEATH

Reg. Dist. No.

04219

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia 47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington-Geo. & Hospital</u>			d. STREET ADDRESS <u>2205 California St. N.W.</u>		
3. NAME OF DECEASED (Type or print) <u>Helen</u>			4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-81</u>	9. AGE (In years last birthday) <u>75</u> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward Allen Fay</u>			14. MOTHER'S MAIDEN NAME <u>Mary Bradshaw</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>Allen B. Fay</u>		
17. INFORMANT <u>Nephew - 2 Ardmore Circle, Wash 13, DC</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepato-Renal syndrome due to</u> <u>581.0</u> DUE TO (b) <u>Terminal stage of Portal Cirrhosis</u> DUE TO (c) <u>With Esophageal Varicoes and Ascites</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>2 yrs.</u>			20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct</u> , 1955, to <u>April 22</u> , 1957, that I last saw the deceased alive on <u>April 22</u> , 1957, and that death occurred at <u>5:15</u> P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.			ADDRESS (Street, city or town, state) <u>809 Davis Ave, Takoma Park, Md</u> DATE SIGNED <u>4/22/57</u>		
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>			<u>809 Davis Ave, Takoma Park, Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	
22d. LOCATION (City, town or county) (State) <u>Quintland Rd. Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u> ADDRESS <u>5103 Wisconsin Ave NW Wash 16</u>			
24a. REG'D BY REGISTRAR <u>4-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF MINISTER OF GOSPEL		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF BURIAL	
25. SIGNATURE OF INTERMENT		26. SIGNATURE OF RECORDS		27. SIGNATURE OF VITALS	
28. SIGNATURE OF DEATH		29. SIGNATURE OF BURIAL		30. SIGNATURE OF INTERMENT	
31. SIGNATURE OF RECORDS		32. SIGNATURE OF VITALS		33. SIGNATURE OF DEATH	
34. SIGNATURE OF BURIAL		35. SIGNATURE OF INTERMENT		36. SIGNATURE OF RECORDS	
37. SIGNATURE OF VITALS		38. SIGNATURE OF DEATH		39. SIGNATURE OF BURIAL	
40. SIGNATURE OF INTERMENT		41. SIGNATURE OF RECORDS		42. SIGNATURE OF VITALS	
43. SIGNATURE OF DEATH		44. SIGNATURE OF BURIAL		45. SIGNATURE OF INTERMENT	
46. SIGNATURE OF RECORDS		47. SIGNATURE OF VITALS		48. SIGNATURE OF DEATH	
49. SIGNATURE OF BURIAL		50. SIGNATURE OF INTERMENT		51. SIGNATURE OF RECORDS	
52. SIGNATURE OF VITALS		53. SIGNATURE OF DEATH		54. SIGNATURE OF BURIAL	
55. SIGNATURE OF INTERMENT		56. SIGNATURE OF RECORDS		57. SIGNATURE OF VITALS	
58. SIGNATURE OF DEATH		59. SIGNATURE OF BURIAL		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF RECORDS		62. SIGNATURE OF VITALS		63. SIGNATURE OF DEATH	
64. SIGNATURE OF BURIAL		65. SIGNATURE OF INTERMENT		66. SIGNATURE OF RECORDS	
67. SIGNATURE OF VITALS		68. SIGNATURE OF DEATH		69. SIGNATURE OF BURIAL	
70. SIGNATURE OF INTERMENT		71. SIGNATURE OF RECORDS		72. SIGNATURE OF VITALS	
73. SIGNATURE OF DEATH		74. SIGNATURE OF BURIAL		75. SIGNATURE OF INTERMENT	
76. SIGNATURE OF RECORDS		77. SIGNATURE OF VITALS		78. SIGNATURE OF DEATH	
79. SIGNATURE OF BURIAL		80. SIGNATURE OF INTERMENT		81. SIGNATURE OF RECORDS	
82. SIGNATURE OF VITALS		83. SIGNATURE OF DEATH		84. SIGNATURE OF BURIAL	
85. SIGNATURE OF INTERMENT		86. SIGNATURE OF RECORDS		87. SIGNATURE OF VITALS	
88. SIGNATURE OF DEATH		89. SIGNATURE OF BURIAL		90. SIGNATURE OF INTERMENT	
91. SIGNATURE OF RECORDS		92. SIGNATURE OF VITALS		93. SIGNATURE OF DEATH	
94. SIGNATURE OF BURIAL		95. SIGNATURE OF INTERMENT		96. SIGNATURE OF RECORDS	
97. SIGNATURE OF VITALS		98. SIGNATURE OF DEATH		99. SIGNATURE OF BURIAL	
100. SIGNATURE OF INTERMENT		101. SIGNATURE OF RECORDS		102. SIGNATURE OF VITALS	

BUREAU V. S.

APR 29 1957

RECEIVED

4176

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last JOSIAH DEMING FERGUSON				4. DATE OF DEATH Month Day Year APRIL 13 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-91	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER - retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME WILLIAM P. F. FERGUSON				14. MOTHER'S MAIDEN NAME GRACE HATHAWAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW # 1		17. INFORMANT Mrs. Louise C. Ferguson, 8359 Colesville Rd. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 336X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks. 2-3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 10, 1940, to April 12, 1957, that I last saw the deceased alive on April 12, 1957, and that death occurred at 8:10 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. WARDROP				DATE SIGNED 8-37 Bonifant St. Silver Spring, Md.			
PHYSICIAN'S NAME (Type) W. B. WARDROP				ADDRESS (Street, city or town, state) 837 BONIFANT ST. SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/13/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey,				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/15/57	
				24b. REGISTRAR'S SIGNATURE J. Wilson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		SINGLE		WIDOW		DIVORCED		RE-MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		DEGREE		FIELD		DATE	
RELIGION		CHURCH		SYNAGOGUE		TEMPLE		MOSQUE		OTHER		DATE OF BAPTISM		PLACE OF BAPTISM	
CAUSE OF DEATH		DISEASE		INJURY		POISON		SUFFOCATION		DROWNING		FIRE		OTHER	
DATE OF DEATH		TIME		PLACE		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL	
NAME OF FUNERAL HOME		ADDRESS		CITY		STATE		COUNTRY		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
NAME OF PHYSICIAN		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	
NAME OF CORONER		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	
NAME OF JURY		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	
NAME OF WITNESS		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	
NAME OF SIGNER		ADDRESS		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY	

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4291

CERTIFICATE OF DEATH

Reg. Dist. No.

04221

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium		d. STREET ADDRESS 1825 G Street, N. W.	
3. NAME OF DECEASED (Type or print) EDWARD First FRANCIS Last		4. DATE OF DEATH Month April Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Shandon, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abner Francis		14. MOTHER'S MAIDEN NAME Martha Ann Vaughan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Charles R. Armstrong		Address 7605 Meadow La. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fever of unknown origin 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized. Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 50 to April 19 57 , that I last saw the deceased alive on April 11, 19 57 , and that death occurred at 730 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Conn. Ave., NW Wash, D.C. DATE SIGNED ACTUAL SIGNATURE F. G. Mac Murray M.D. PHYSICIAN'S NAME (Type) F. G. Mac Murray 1150 Conn. Ave., N.W., Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-16-57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Shandon Cemetery		22d. LOCATION (City, town, or county) (State) Shandon, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 4-15-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIAGE		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	
CITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE		DIVISION OF VITAL STATISTICS	
WASHINGTON, D.C.		20001	

BUREAU V. S.

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Montgomery <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Lodge				d. STREET ADDRESS Chestnut Lodge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frieda First Fromm-Reichmann Middle Reichmann Last				4. DATE OF DEATH 4/28/57 Month 4 Day 28 Year 19			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolph Reichmann				14. MOTHER'S MAIDEN NAME Klara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Chestnut Lodge Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thrombosis Left Descend Coronary Artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, Coronary Art. Arteriosclerosis DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 2 years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bath tub filled with water					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Nanzan				24. REC'D BY REGISTRAR 5-8-57		24b. REGISTRAR'S SIGNATURE Barrie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		May 1, 1957	
Place of Death		Cause of Death		Manner of Death		Occupation	
New York City		Heart Disease		Natural		Teacher	
Physician		Hospital		Burial		Funeral Home	
Dr. Smith		St. John's		Catholic		Doe & Sons	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU N. Y.

MAY 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04223
223

4177

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>802 Tanley Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Charles</u> Last <u>Eyles</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>14</u> - Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-01</u>	9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Comm</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver C. Eyles</u>				14. MOTHER'S MAIDEN NAME <u>Lula Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-6190</u>		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>Generalized arteriosclerotic vascular disease 2 yrs.</u> DUE TO (c) <u>Possible undiagnosed mild diabetes ?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>General myocardial disease on a coronary insufficiency basis.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>April 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest E. Harmon</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>9301 Colesville Road, Silver Spring, 4/14/ Maryland 57</u>			
PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM CHURCH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>GLASTONBURY, CONNECTICUT</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/16/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04224

Reg. Dist. No. 218

4242

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			c. LENGTH OF STAY IN 1b 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x 2 Gaithersburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakmont Ave. RFD #3				d. STREET ADDRESS Oakmont Ave. RFD # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Leslie Last Gossett				4. DATE OF DEATH Month 4 Day 26 Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/05		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 247-05-1711		17. INFORMANT Nancy Gossett (wife) Address Same # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/26/57	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-57		22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. REC'D BY REGISTRAR Apr. 29-57		24b. REGISTRAR'S SIGNATURE Abraham G. Cooke	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04225

214

4243

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		d. STREET ADDRESS 2606 Arcola Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna C. Gravalles		4. DATE OF DEATH Month 4 Day 25 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/77
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR: Months 1 Days 5 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Butt		14. MOTHER'S MAIDEN NAME Anna C. Schryer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George Buckler		2606 Arcola Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 31 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1947 , to April 1957 , that I last saw the deceased alive on April 25, 1957 , and that death occurred at 11:22 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kreuzburg		M.D. 7852 16 58. NW DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) H. F. Kreuzburg		Wash 12 DE	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR APR 29 1957	
24b. REGISTRAR'S SIGNATURE Frances Potter			

BUREAU V. S.

APR 29 1957

RECEIVED

4241

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>5211 Roosevelt St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Halford</u> Middle <u>Robert</u> Last <u>GREENLEE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 Dec. 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Archibald W. Greenlee</u>		14. MOTHER'S MAIDEN NAME <u>Olive Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 9-7-01 to 6-30-40</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Son) Halford R. Greenlee, Jr. (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>17 April</u> , 19 <u>57</u> , to <u>22 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 April</u> , 19 <u>57</u> , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-23-57</u>							
ACTUAL SIGNATURE <u>R. J. Cales</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. J. CALES, LCDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u>				ADDRESS <u>1557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-22-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALLIANCE STATE DEPARTMENT OF HEALTH—BIRMINGHAM 19

RECEIVED
APR 24 1957
BUREAU T. S.

4245

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Montgomery County General Hospital		e. STREET ADDRESS 13X02	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First George Middle Edgar Last Gregg		4. DATE OF DEATH Month April Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/72
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elisha Gregg		14. MOTHER'S MAIDEN NAME Catherine Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 NO		16. SOCIAL SECURITY NO. ✓	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Biliary Cirrhosis of Liver (c) Hepatic Duct Obstruction.			INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mo. 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/2, 1957 , to 4/11, 1957 , that I last saw the deceased alive on 4/11, 1957 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Higgin		ADDRESS (Street, city or town, state) Sandy Spring, Md	
PHYSICIAN'S NAME (Type) C. H. Higgin		DATE SIGNED 4/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/14/57	22c. NAME OF CEMETERY OR CREMATORY Pine Grove	22d. LOCATION (City, town, or county) (State) Mt Airy, Md
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton, Barnesville, Md		24a. REC'D BY REGISTRAR DATE 4/15/57	24b. REGISTRAR'S SIGNATURE Charles W. Elgin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MONTGOMERY		2. SEX Male		3. AGE 11 days		4. RACE White		5. BIRTH DATE April 11, 1957		6. BIRTH PLACE Baltimore, Maryland		7. PLACE OF BIRTH Baltimore, Maryland		8. DATE OF DEATH April 11, 1957		9. TIME OF DEATH 11:00 AM		10. CAUSE OF DEATH Stillborn		11. PLACE OF DEATH Home		12. SIGNATURE OF PHYSICIAN J. F. [Signature]		13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF WITNESS [Signature]		21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]		25. SIGNATURE OF WITNESS [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF WITNESS [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF WITNESS [Signature]		31. SIGNATURE OF WITNESS [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF WITNESS [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF WITNESS [Signature]		37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF WITNESS [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF WITNESS [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF WITNESS [Signature]		46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF WITNESS [Signature]		49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF WITNESS [Signature]		52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF WITNESS [Signature]		56. SIGNATURE OF WITNESS [Signature]		57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF WITNESS [Signature]		61. SIGNATURE OF WITNESS [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF WITNESS [Signature]		64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF WITNESS [Signature]		69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF WITNESS [Signature]		73. SIGNATURE OF WITNESS [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF WITNESS [Signature]		76. SIGNATURE OF WITNESS [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF WITNESS [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF WITNESS [Signature]		81. SIGNATURE OF WITNESS [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF WITNESS [Signature]		85. SIGNATURE OF WITNESS [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF WITNESS [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF WITNESS [Signature]		91. SIGNATURE OF WITNESS [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF WITNESS [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF WITNESS [Signature]		97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF WITNESS [Signature]	
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RECEIVED
APR 18 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01228**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN lb 8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodmore Cleaners, 10119 Colesville Rd.				d. STREET ADDRESS 1426 K St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Gregory Last				4. DATE OF DEATH Month 4/25/57 Day 19 Year			
5. SEX male		6. COLOR OR RACE ool		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (State or foreign country) South Carolina			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Rosa Lanton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Police Record Address Dorthy Johnson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Hall Bros. Funeral Home		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				24a. RECD BY REGISTRAR 24b. REGISTRAR'S SIGNATURE APR 30 1957 <i>Frances Pottery</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FOR BURIAL, CREMATION, or removal.**

104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1957

RECEIVED

4247

CERTIFICATE OF DEATH

Reg. Dist. No.

04229
272

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Poolesville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) RFD - Poolesville				e. STREET ADDRESS RFD - Poolesville			
3. NAME OF DECEASED (Type or print) First ERNEST Middle Mazo Last GRUBB				4. DATE OF DEATH Month April Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/29/87	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 4 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Secy.				10b. KIND OF BUSINESS OR INDUSTRY Y. M. C. A.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Winton E. Grubb				14. MOTHER'S MAIDEN NAME Catherine Lindamood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 114-26-5885		17. INFORMANT Mrs Mabel L. Grubb- Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parkinson's Disease DUE TO (c) Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Dec , 19 52 , to 24 April , 19 57 , that I last saw the deceased alive on 24 April , 19 57 , and that death occurred at 10 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John G. Fawcett MD				ADDRESS (Street, city or town, state) P.O. Baycol, Md 4/25/57			
DATE SIGNED JOHN G. FAWCETT MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Presby. Church Cem.		22d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumpfrey-Bethesda, Md.				24a. REC'D BY REGISTRAR APR 29 1957		24b. REGISTRAR'S SIGNATURE Charles Elgin	

4248

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN TB <u>5 yrs.</u>				d. STREET ADDRESS <u>8401 Seven Locks Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8401 Seven Locks Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Guttersen</u> Last <u>Guttersen</u>			4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota, Gallatin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>516-16-1842</u>		17. INFORMANT Address <u>Bethesda, Md.</u> <u>Alston Guttersen, 8401 Seven Locks Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, right lung</u> <u>162x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease Chronic Emphysema</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY 13</u> , 19 <u>53</u> , to <u>APRIL 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>APRIL 1</u> , 19 <u>57</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>April 2, 1957</u>							
ACTUAL SIGNATURE <u>Robert G. Angle</u>		M.D. <u>5009 Del Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>April 2, 1957</u>					
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans.</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sun Set Hills</u>		22d. LOCATION (City, town, or county) (State) <u>Minnesota, Gallatin Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04231

Item 20b Film G21 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5-6-57 jp

4249

Items 7, 13, 14 Film G21 5-3-57 et.

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 5125 8th St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Hamilton Last Hamilton		4. DATE OF DEATH Month Apr Day 20 Year 1957	
5. SEX female	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-1920
9. AGE (in years, last birthday) 36 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 6 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute traumatic shock DUE TO 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Contusion - Ruptured spleen. DUE TO Fracture, both bones, Rt leg (c) Fracture, both bones, Rt leg			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Passenger in car passing other vehicle when struck head on.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6:47 a. m. 4/20/57		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Bethesda (County) Montg. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/24/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY WILLIAMSBURG,		22d. LOCATION (City, town, or county) VIRGINIA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis Co., 1432 You St., N.W.		24a. REC'D BY REGISTRAR APR 29 1957	
		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and other details. The text is mostly illegible due to the quality of the scan.

Signature of Medical Examiner: _____
Date: _____

RECEIVED
BUREAU V. S.
APR 29 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

4250

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 37 hrs 5 mi		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 5125 8th St. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice B Hamilton				4. DATE OF DEATH 4/21/57 Month Day Year			
5. SEX male		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/30/1908 yrs. 48	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WALLIE HAMILTON SR				14. MOTHER'S MAIDEN NAME EMMA HILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT Hosp. Records - Wallie Hamilton SR Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delayed Traumatic Shock 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral confusion, Fractured pelvis DUE TO (c) Auto Accident INTERVAL BETWEEN ONSET AND DEATH 37 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was driver of car involved in auto. accident			
20c. TIME OF INJURY Hour a. m. 6:47 57 Month, Day, Year 4/20/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Jarvis Co. 1432 You St. NW				24a. REC'D BY REGISTRAR DATE 4/26/57		24b. REGISTRAR'S SIGNATURE Mary Carroll	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED
JUN 25 1957

4251

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown. R F D #1		c. LENGTH OF STAY IN 1b 4 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Germantown Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William First Clinton Harding Last		4. DATE OF DEATH Apr 26 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15-1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR 3 Months 11 Days 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B&O RR Employee,		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland (Frederick Co)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Harding		14. MOTHER'S MAIDEN NAME Mary Ellen Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Benjamin J. Harding, Germantown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart DUE TO Brain (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to Apr 26, 1957 , that I last saw the deceased alive on Apr 26, 1957 , and that death occurred at 6:20 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher M.D.		ADDRESS (Street, city or town, state) 26 N. Summit Ave. Gaithersburg, Md.	
DATE SIGNED 4-26-57			
PHYSICIAN'S NAME (Type) Jack Schumacher M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR Apr 29 57		24b. REGISTRAR'S SIGNATURE Charles L. Coyle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
OCCASION OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		MARITAL STATUS [Faint text]	
PREVIOUS ILLNESS [Faint text]		PREVIOUS SURGERY [Faint text]		PREVIOUS TRAUMA [Faint text]	
PREVIOUS DRUGS [Faint text]		PREVIOUS ALCOHOL [Faint text]		PREVIOUS TOBACCO [Faint text]	
PREVIOUS RADIATION [Faint text]		PREVIOUS CHEMICALS [Faint text]		PREVIOUS OTHER [Faint text]	
PREVIOUS INJURY [Faint text]		PREVIOUS DISEASE [Faint text]		PREVIOUS TREATMENT [Faint text]	
PREVIOUS HOSPITALIZATION [Faint text]		PREVIOUS PHYSICIAN [Faint text]		PREVIOUS NURSE [Faint text]	
PREVIOUS OTHER [Faint text]		PREVIOUS OTHER [Faint text]		PREVIOUS OTHER [Faint text]	

BUREAU V. 3

MAY 1 1957

RECEIVED

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 31

APR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04235

4253

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>Mason Drive Frederick</i>			
3. NAME OF DECEASED (Type or print) <i>Patricia Ann Harri-day</i>				4. DATE OF DEATH <i>April 12 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 18/57</i>	
9. AGE (In years lost birthday) <i>4</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>12</i> Hours <i>12</i> Min. <i>12</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>John A Harri-day</i>				14. MOTHER'S MARRIED NAME <i>Della M Crockett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>762.5</i>			
17. INFORMANT <i>mother</i>				Address <i>(same)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Very immature premature</i> DUE TO (c) <i>4 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>April 8, 1957</i> , to <i>April 12, 1957</i> , that I last saw the deceased alive on <i>April 12, 1957</i> , and that death occurred at <i>7:15</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Vernant L. Donnell</i> M.D.				ADDRESS (Street, city or town, state) <i>8218- Wisc Ave</i>			
PHYSICIAN'S NAME (Type) <i>Robert L. Snowden</i>				DATE SIGNED <i>Book 4/17/57</i>			
22a. BURIAL, CREMATION, or other disposition (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/21/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park,</i>		22d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>				ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>APR 23 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>			

2074253XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		April 22, 1928		Memphis, Tennessee	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
Actor		Suicide		Homicide		Home		11:00 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

APR 23 1967

RECEIVED

Mississippi

Memphis, TN

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

4254 Items 8,9 FilmG213 4-11-57 et CERTIFICATE OF DEATH

Reg. Dist. No. **04236**
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>35 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POOLESVILLE - Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>G</u> Last <u>Hebron</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1957</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 20, 1922</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Hebron</u>						14. MOTHER'S MAIDEN NAME <u>Susie Driver</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Viola Hebron - Rockville Md.</u> General Delivery									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous Pneumothorax & Subcut. Emphysema.</u> <u>518x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho pleural fistula</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>16 June</u> , 19 <u>57</u> , to <u>2 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 April</u> , 19 <u>57</u> , and that death occurred at <u>1450</u> M. from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Monten T. White</u> M.D.						ADDRESS (Street, city or town, state) <u>11134 Calver road</u>						DATE SIGNED <u>5 Apr 1957</u>			
PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u>				22d. LOCATION (City, town, or county) (State) <u>Summerville, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surnden</u>						ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>APR 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1057

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF REGISTRAR</p>	

APR 8 1957

BUREAU V. S.

RECEIVED

4178

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Jan. + Hosp.</u>				d. STREET ADDRESS <u>11009 Notley Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Agnes Elizabeth Hecht</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-73</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>JOHN D. Mac Nair</u>				14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Chart (Hosp. record)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>April 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>57</u> , and that death occurred at <u>5:28</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u>				ADDRESS (Street, city or town, state) <u>9301 Coleridge Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR.</u>				DATE SIGNED <u>April 20, '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>4/23/57</u>		<u>GREENWOOD CEMETERY</u>		<u>BROOKLYN, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u>				24. REC'D BY REGISTRAR <u>APR 23 1957</u>			
ADDRESS <u>8434 Longview Rd.</u>				24b. REGISTRAR'S SIGNATURE <u>J. H. Wilson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		DATE OF MARRIAGE		PLACE OF MARRIAGE	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF OTHER	

BUREAU V. S.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *210*

04238

4255

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6424 - 79th Street				d. STREET ADDRESS 6424 - 79th Street			
3. NAME OF DECEASED (Type or print) First Arthur Middle Franklin Last HILL				4. DATE OF DEATH Month April Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 5 Days 21		IF UNDER 24 HRS. Hours 21 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Army Engineer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cropley, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Levi Hill				14. MOTHER'S MAIDEN NAME Julie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dorothy A. Wright, 6424 79th St. Cabin John			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Shotgun wound in left chest DUE TO (c) sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self-inflicted shotgun wound in left chest							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted shotgun wound in left chest			
20c. TIME OF INJURY Hour 2:46 p. m. Month, Day, Year 4/18 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cabin John Montg. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 4-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED CASHIN, JOHN		AGE 34		SEX Male		RACE White		DATE OF DEATH April 24, 1957		PLACE OF DEATH Home	
RESIDENCE 1424 - 17th Street		CITY Baltimore		COUNTY Baltimore		STATE Maryland		OCCUPATION None		CAUSE OF DEATH Gun-inflicted wound in left chest	
MANNER OF DEATH Homicide		MEDICAL HISTORY None		PREVIOUS ILLNESS None		TREATMENT None		POST-MORTEM None		SIGNATURE OF EXAMINER BUREAU T. R.	

RECEIVED
 APR 24 1957
 BUREAU T. R.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G214 5-1-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04239
214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville,				c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Spring, R. F. D. # 2				d. STREET ADDRESS Silver Spring, R. F. D. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle McAllister Last Howard				4. DATE OF DEATH Month April Day 22 Year 57			
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Mc Allister				14. MOTHER'S MAIDEN NAME Rachel Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Florence Boston Address Silver Spring, Md. R. F. D. # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism 156.1 DUE TO Cardiorenal Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Hepatica (c) 14 mos.						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 20yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis, Asthma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 20, 1936 to April 22, 1957 , that I last saw the deceased alive on April 22, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Webster Sewell M.D.				NORBECK, RFD 1 Silver Spring, M			
PHYSICIAN'S NAME (Type) Webster Sewell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/57		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR APR 29 1957	
				24b. REGISTRAR'S SIGNATURE Frances Colley			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion	
Catherine		11		Female		Caucasian		Roman Catholic	
Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death	
1898		New York		1909		New York		Diphtheria	
Occupation		Education		Marital Status		Previous Illnesses		Burial Place	
None		None		Single		None		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

1909 09 1057

RECEIVED

[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G211 5-1-57 et

4293

CERTIFICATE OF DEATH

Reg. Dist. No.

04240

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Rockville Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR (Nursing home)</u>		d. STREET ADDRESS <u>12201 Rockville Pike</u>	
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>HUDSON</u> Last <u>HUDSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-26</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Capt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Ind. Rhod. - atty for estate.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA - GANGRENE (both legs)</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic vascular Disease</u> DUE TO (c) <u>with chronic cellulitis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema & coronary heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> , 19 <u> </u> , to <u>April 24, 1957</u> , that I last saw the deceased alive on <u>April 22, 1957</u> , and that death occurred at <u>3:20 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Nickle</u> M.D.		ADDRESS (Street, city or town, state) <u>4830 - V St. N.W. WASH. D.C.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>4/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co - D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>4/24/57</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence Fragotz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John M. Smith</i>		DATE OF DEATH <i>April 26, 1957</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Engineer</i>		RESIDENCE <i>1234 Main St., Baltimore, Md.</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. K. Jones</i>		SIGNATURE OF REGISTRAR <i>John M. Smith</i>	
DATE OF SIGNATURE <i>April 26, 1957</i>		DATE OF SIGNATURE <i>April 26, 1957</i>	

BUREAU V. S.

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04241

4257

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Loretta Last Hudson				4. DATE OF DEATH Month April Day 19 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/29/88 88	
9. AGE (In years last birthday) 70:68 yrs.		IF UNDER 1 YEAR Months 7 Days 20 Hours 20 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Knott				14. MOTHER'S MAIDEN NAME Mary A. Arlen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor of Stomach, presumably malignant 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, diabetes.						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Inne , 19 55 , to April 19 , 19 57 , that I last saw the deceased alive on April 19 , 19 57 , and that death occurred at 2:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. F. Meadors, M. D.				ADDRESS (Street, city or town, state) Damascus, Md.			
DATE SIGNED 4/20/57							
PHYSICIAN'S NAME (Type) G. F. Meadors, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harold C. Gartner				ADDRESS Gaithersburg, Md		24a. REC'D BY REGISTRAR DATE 4-22-57	
				24b. REGISTRAR'S SIGNATURE Leatrice B. Lanier			

212

4253

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) BROOKE GROVE FOUNDATION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDNA MARIE HULL		4. DATE OF DEATH APRIL 28 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 21, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY (retired)	
11. BIRTHPLACE (State or foreign country) CREAGERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES M. HULL		14. MOTHER'S MAIDEN NAME SARAH MARGARET ROBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LAWRENCE C. RABBITT		Address 11,406 NEWPORT MILL RD., SS.MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) essential hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 904.9 Fracture hip 2 mos ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/15/50 , 19____, to 4/28 , 19____, that I last saw the deceased alive on 4/29/57 , 19____, and that death occurred at 6 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Patrick C. Jameson M.D. 1202 Overglen 4/29/57			
ACTUAL SIGNATURE Patrick C. Jameson		PHYSICIAN'S NAME (Type) PATRICK C JAMESON	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 30, 1957	
22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) ROCKVILLE, MONTGOMERY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR 5-7-57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990-1991

7

BUREAU V. 8.

MAY 9 1957

RECEIVED

4259

CERTIFICATE OF DEATH

Reg. Dist. No. ~~XX~~ 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>ST M.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>12 hrs. 20 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>Route #1, Box 433</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Patti</u> Middle <u>Lynn</u> Last <u>HYATT</u>		4. DATE OF DEATH		Month <u>April</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1957</u>		9. AGE (In years last birthday) yrs. <u>12</u>	IF UNDER 1 YEAR: Months <u>12</u> Days <u>20</u> IF UNDER 24 HRS. Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence Hyatt</u>				14. MOTHER'S MAIDEN NAME <u>Joan Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Official Navy Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal primary atelectasis</u> DUE TO (c) <u>12 1/2 hr</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>25 April</u> , 19 <u>57</u> , to <u>25 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 April</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-26-57</u>							
ACTUAL SIGNATURE <u>John H. Mazur</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>					
PHYSICIAN'S NAME (Type) <u>John H. Mazur, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1 May 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county)		(State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey, (55) Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>4-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051221XV2

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE		EDUCATION	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS	
TREATMENT		PATHOLOGICAL FINDINGS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04243

4260

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 11 hrs. 50 m	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Colesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hos. Inc.		d. STREET ADDRESS 1237 Colesville-Beltsville Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Jackson Last Jackson		4. DATE OF DEATH Month April Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/57
9. AGE (In years last birthday) NB yrs.		10. IF UNDER 1 YEAR Months 11 Days 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Richard John Jackson		14. MOTHER'S MAIDEN NAME Margaret Ann Davenport	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Richard John Jackson		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH at birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Prematurity	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/11 , 19 57 , to 4/12 , 19 57 , that I last saw the deceased alive on 4/11 , 19 57 , and that death occurred at 11:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Olney, Maryland DATE SIGNED Robert R. Sworden			
ACTUAL SIGNATURE Robert R. Sworden		M.D. Olney, Maryland	
PHYSICIAN'S NAME (Type) R.A. Yates, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/57	
22c. NAME OF CEMETERY OR CREMATORY Good Hope		22d. LOCATION (City, town, or county) (State) Colesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Sworden		24a. REC'D BY REGISTRAR DATE 22 1957	
ADDRESS Rockville, Md		24b. REGISTRAR'S SIGNATURE Gertrude Lowery	

2099212 XVI

BUREAU U. S.

APR 22 1957

RECEIVED

4261
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Rockbridge			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 mo. 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stanton 83 x -3			
d. STREET ADDRESS Raphing Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Franklin Last JARVIS				4. DATE OF DEATH Month April Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1 Feb. 1901		9. AGE (In years last birthday) yrs. 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Jarvis				14. MOTHER'S MAIDEN NAME Elizabeth Zimmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1-23-42 to 3-14-43		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Sarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 March , 19 57 , to 23 April , 19 57 , that I last saw the deceased alive on 23 April , 19 57 , and that death occurred at 3:08 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Henry B. Karpinski M.D. U.S. Naval Hospital, Bethesda, Md. 4-23-57							
ACTUAL SIGNATURE Henry B. Karpinski				PHYSICIAN'S NAME (Type) Henry B. Karpinski, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57		22c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery		22d. LOCATION (City, town, or county) (State) Rockbridge County, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE K.A. Pumphrey ADDRESS 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 4-23-57		24b. REGISTRAR'S SIGNATURE Mary E. Carrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]		10. EDUCATION [Illegible]		11. SOCIAL SECURITY NUMBER [Illegible]		12. DATE OF DEATH [Illegible]	
13. TIME OF DEATH [Illegible]		14. PLACE OF DEATH [Illegible]		15. CAUSE OF DEATH [Illegible]		16. MANNER OF DEATH [Illegible]		17. SIGNATURE OF PHYSICIAN [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	

BUREAU OF

APR 25 1954

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4:62

Item 14 Film 214 5-2-57 et

Reg. Dist. (14245)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Joliet</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joliet</u> 51X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>JESS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Oct. 1936</u>	9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u>20</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Lee Jess</u>				14. MOTHER'S MAIDEN NAME <u>Verna Keithley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 2-16-55 to 4-17-57</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Brain</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture, Comminuted, base of cranium</u> DUE TO (c) <u>5 hours</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver In Auto in Street, Failed to negotiate Turn.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>1:37</u> a. m. <u>PM</u> <u>Apr. 17 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	20f. (City or town) <u>Naval Air Sta. Patuxent River, Md.</u>	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bellevue, Iowa</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>4-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>May G. Carvelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

4263

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			
c. LENGTH OF STAY IN 1b <u>16 hrs. 45 min.</u>				d. STREET ADDRESS <u>Box 13</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp. Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Smith</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Franklin Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>132-16</u>		17. INFORMANT <u>Arthur Herbert Johnson</u>		Address <u>Box 13 Olney, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4200</u> DUE TO <u>with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerosis / Heart Disease 15 yrs</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 15, 1957</u> to <u>Apr. 16, 1957</u> , that I last saw the deceased alive on <u>Apr. 15, 1957</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Maryland</u> DATE SIGNED <u>4-16-57</u>							
ACTUAL SIGNATURE <u>J. Schumacher, M.D.</u>				PHYSICIAN'S NAME (Type) <u>J. Schumacher, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>APRIL 18 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lanhamville Md</u>	
22d. LOCATION (City, town, or county) <u>Montgomery</u>				(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W BARBER</u>				ADDRESS <u>LANHAMVILLE</u>		24a. REC'D BY REGISTRAR <u>4-16-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawley</u>							

CERTIFICATE OF DEATH

6533

112

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

APR 23 1957

RECEIVED

11-10-22

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05349

Items 22, 23 File G215 5-15-57 et

CERTIFICATE OF DEATH

~~DECLARATION COPY~~ Reg. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS Rt. #2, Box 71	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Mitchell Last Johnson		4. DATE OF DEATH Month April Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/77
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Lucy Jane Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1940, to April 14 , 1957, that I last saw the deceased alive on April 14 , 1957, and that death occurred at 9:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Md. DATE SIGNED Charles S. Whitaker, M. D.			
ACTUAL SIGNATURE Charles S. Whitaker, M. D.		M.D. Clarksville, Md.	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D.		ADDRESS Clarksville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-57	
22c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel Cem.		22d. LOCATION (City, town, or county) (State) Highland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.		ADDRESS Ellicott City, Md.	
24a. REC'D BY REGISTRAR 5-9-57		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

CERTIFICATE OF DEATH

HYATTSPRING CASE 1007

NAME OF DECEASED John James Johnson		AGE 35		SEX Male		RACE White	
DATE OF DEATH July 14, 1957		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		CITY Hyattsville	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		OCCUPATION Salesman		EDUCATION High School	
PREVIOUS ILLNESS None		TREATMENT None		HISTORY None		FAMILY HISTORY None	
SIGNATURE OF PHYSICIAN [Signature]		DATE July 14, 1957		SIGNATURE OF REGISTRAR [Signature]		DATE July 14, 1957	
LOCAL HEALTH OFFICE [Signature]		DATE July 14, 1957		STATE HEALTH OFFICE [Signature]		DATE July 14, 1957	

BUREAU V. 4

AV 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04247

4265

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. M.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 74 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park 18x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 691 Chinlee Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margie Middle Ann Last JOHNSON				4. DATE OF DEATH Month April Day 1 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Sept. 1931	
9. AGE (In years last birthday) 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Mc Culley				14. MOTHER'S MAIDEN NAME Hazel Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband, Curtis M. Johnson, Jr. (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hodgkins Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Carlton, Alabama				20g. (County) (State)			
21. I certify that I attended the deceased from 17 Jan. , 19 57 , to 1 April , 19 57 , that I last saw the deceased alive on 1 April , 19 57 , and that death occurred at 3:12 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. S. Dunn Jr.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 4-2-57							
PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery		22d. LOCATION (City, town, or county) (State) Carlton, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				24a. REC'D BY REGISTRAR DATE 4-2-57			
24b. REGISTRAR'S SIGNATURE May E. Parrelly							

CERTIFICATE OF DEATH

1957

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA	
MARRIAGE MARRIED		DATE OF MARRIAGE JUL 10 1956		PLACE OF MARRIAGE MEMPHIS, TENN	
OCCUPATION MEMBER OF CONGRESS		DATE OF DEATH APR 4 1968		PLACE OF DEATH MEMPHIS, TENN	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. J. H. HARRIS	
DATE OF DEATH APR 4 1968		TIME OF DEATH 2:01 PM		PLACE OF DEATH MEMPHIS, TENN	
NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA	
MARRIAGE MARRIED		DATE OF MARRIAGE JUL 10 1956		PLACE OF MARRIAGE MEMPHIS, TENN	
OCCUPATION MEMBER OF CONGRESS		DATE OF DEATH APR 4 1968		PLACE OF DEATH MEMPHIS, TENN	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANT DR. J. H. HARRIS	
DATE OF DEATH APR 4 1968		TIME OF DEATH 2:01 PM		PLACE OF DEATH MEMPHIS, TENN	

BUREAU V. S.

APR 4 1968

RECEIVED

4266

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 3210 13th, S.E. Apt. #2			
3. NAME OF DECEASED (Type or print) First Peter Middle Robert Last JUERGENSEN				4. DATE OF DEATH Month April Day 23 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 April 1957	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Arthur Peter Juergensen				14. MOTHER'S MAIDEN NAME Lillian Rochester			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Arthur P. Juergensen (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL ATELECTASIS 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH INDEFINITE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 22 April , 19 57 , to 23 April , 19 57 , that I last saw the deceased alive on 23 April , 19 57 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-24-57							
ACTUAL SIGNATURE Daniel Shupstar				M.D. U.S. Naval Hospital, Bethesda, Md. 4-24-57			
PHYSICIAN'S NAME (Type) Daniel Shupstar, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Humphrey				24a. REC'D BY REGISTRAR 4-24-57		24b. REGISTRAR'S SIGNATURE Mary E. Carrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051221XV6

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DECEASED NAME LAST, FIRST, MIDDLE (Print or type)		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS (Print or type)		RACE (Print or type)	
DATE OF DEATH YEAR MONTH DAY (Print or type)		PLACE OF DEATH (Print or type)	
TIME OF DEATH (Print or type)		CAUSE OF DEATH (Print or type)	
MANNER OF DEATH (Print or type)		PLACE OF BIRTH (Print or type)	
OCCUPATION (Print or type)		MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
EDUCATION (Print or type)		RELIGION (Print or type)	
PREVIOUS ILLNESS (Print or type)		MEDICAL HISTORY (Print or type)	
PHYSICIAN'S SIGNATURE (Print or type)		MEDICAL EXAMINER'S SIGNATURE (Print or type)	
COUNTY (Print or type)		CITY (Print or type)	

BUREAU V. 4

APR 25 1957

RECEIVED

4267

CERTIFICATE OF DEATH

04249
216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 121 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 52 Michigan Avenue			
3. NAME OF DECEASED (Type or print) First John Middle Katilauckas Last Katilauckas				4. DATE OF DEATH Month April Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Maritime Service		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Eva Katilauckas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 294-03-0275		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of larynx DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cellulitis of skin; Salmonella C. enteritis							INTERVAL BETWEEN ONSET AND DEATH 1 wk 9 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21. I certify that I attended the deceased from December 4, 1956 to April 4, 1957 , that I last saw the deceased alive on April 4, 1957 , and that death occurred at 4:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/9/57							
ACTUAL SIGNATURE Samuel Charache		M.D. The Clinical Center		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Samuel Charache, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/57	22c. NAME OF CEMETERY OR CREMATORY Wash. National		22d. LOCATION (City, town, or county) (State) Suitland, Md			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Wash., D.C.		24a. REC'D BY REGISTRAR DATE APR 11 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1957

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04250

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE NEW YORK b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF TIME IN 1b 6 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3517 Leland Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FREDERICK Middle THEODORE Last KETCHUM				4. DATE OF DEATH Month April Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Procurement officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Frederick C. Ketchum				14. MOTHER'S MAIDEN NAME Elizabeth Hunt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 107-09-3674		17. INFORMANT Police records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate poisoning (Suicide) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Found dead in bed							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 4/25/57		22c. NAME OF CEMETERY OR CREMATORY TIOGA CEMETERY		22d. LOCATION (City, town, or county) _____ (State) _____ BINGHAMTON, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 4-24-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Humphrey			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CARLISBROUGH 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten and printed text.

BUREAU V. 1

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04251

4269

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 2310 Connecticut Ave., N.W.	
3. NAME OF DECEASED (Type or print) First Helen Middle Huber Last KILBURN		4. DATE OF DEATH Month April Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan. 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bartlett J. Cromwell		14. MOTHER'S MAIDEN NAME Lizzie Styles Huber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Niece) Mrs. Elizabeth C. Sypher, (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 24 hrs. unknown unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 April , 19 57 , to 11 April , 19 57 , that I last saw the deceased alive on 11 April , 19 57 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 4-12-57			
ACTUAL SIGNATURE C. U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 April 1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Garland Sorensen		24a. REC'D BY REGISTRAR 4-12-57	
ADDRESS N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Frank B. Parrelly	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		APR 15 1957		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1234 E. BALTIMORE AVE.		LABORER		HEART DISEASE		NATURAL		1234		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		NOTED	
APR 15 1912		BALTIMORE, MARYLAND		HIGH SCHOOL		MARRIED		J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
APR 15 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		1234		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		NOTED	
APR 15 1912		BALTIMORE, MARYLAND		HIGH SCHOOL		MARRIED		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 3

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4270

CERTIFICATE OF DEATH

Reg. Dist. No. 217

04252

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>GAITHERSBURG X 0 MD RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First Middle Last <u>KING</u>		4. DATE OF DEATH <u>APRIL</u> Month <u>21</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 9 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>day work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm & Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-32-7645</u>	
17. INFORMANT <u>Carmie King Gaithersburg MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Connective heart failure + Urinary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Yes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Inguinal Hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>57</u> , to <u>4/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>57</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. L. Ligon</u> M.D.		ADDRESS (Street, city or town, state) <u>Sanby Spring</u> DATE SIGNED <u>4/21/57</u>	
PHYSICIAN'S NAME (Type) <u>C. H. L. Ligon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BROOK GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber, Daytonville Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>4-25-57</u> 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

CERTIFICATE OF DEATH

4370

1. NAME OF DECEASED <i>WILLIAM KIRK</i>		2. SEX <i>Male</i>		3. AGE <i>64</i>	
4. DATE OF DEATH <i>Dec 1 1957</i>		5. TIME OF DEATH <i>11:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
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49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
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55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04253

4271

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ WASHINGTON, D. C. 47x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 2009 EYE STREET, N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JACK (nmi) EUGENE (also known as Jack Eugene Kruppenbacher)				4. DATE OF DEATH Month Day Year APRIL 16 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 29, 1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISCAL ACCOUNTING CLERK			10b. KIND OF BUSINESS OR INDUSTRY U. S. TREASURY		11. BIRTHPLACE (State or foreign country) NEW YORK		
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME JOSEPH KRUPPENBACHER			
14. MOTHER'S MAIDEN NAME KATHERINE REINHARDT				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 111-03-4533				17. INFORMANT Address MD. MRS. JOHN W. MILLER, 9411 WARREN ST., SILVER SPRING,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Massive Myocardial Infarction</p> <p>DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) Thrombosis left circumflex coronary</p> <p>DUE TO</p> <p>(c) Advanced coronary atherosclerosis</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 days</p> <p>2 days</p> <p>? years</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>Rt. hemiplegia from thrombosis left mid. cerebral (8 months)</p>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 1956 to April 16 19 57 that I last saw the deceased alive on April 16 19 57 and that death occurred at 2:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE JASON GEIGER M.D. 931 Pershing Drive				DATE SIGNED 4/16/57			
PHYSICIAN'S NAME (Type) JASON GEIGER Silver Spring, Maryland				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 20, 1957 St. John's Cemetery Forest Glen, Montgomery Co., Md.			
22b. DATE THEREOF April 20, 1957 St. John's Cemetery				22c. NAME OF CEMETERY OR CREMATORY Forest Glen, Montgomery Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey Silver Spring, Md.				24a. REC'D BY REGISTRAR DATE 4-22-57 Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. MEDICAL HISTORY [REDACTED]		11. PRESENT ILLNESS [REDACTED]		12. TREATMENT [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF REGISTRAR [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]	

RECEIVED
BUREAU V. S.
 APR 24 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4272 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04254**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b Since 1948			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2603 Arvin Street				d. STREET ADDRESS 2603 Arvin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last LANGEN				4. DATE OF DEATH Month APRIL Day 22 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 7, 1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL ENGINEER - Navy Dept.				10b. KIND OF BUSINESS OR INDUSTRY New Jersey		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Henry Langen				14. MOTHER'S MAIDEN NAME Betha Hinte			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 101-05-8944		17. INFORMANT Address Mrs. Anne Del'Orme Langen, 2603 Arvin St. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bullet wound in skull DUE TO (c) Sudden</p> </div> <div style="width: 35%;"> <p>ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self inflicted bullet wound in right temple							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Self inflicted bullet wound in right temple					
20c. TIME OF INJURY Month, Day, Year 6:00 a.m. 4/22 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) FRANK J. BROSCHART				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 4/22/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE <i>Frances Patten</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 29 1957

RECEIVED

4273

CERTIFICATE OF DEATH

04255

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 42 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. STREET ADDRESS 7213 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Hixson Last Larkin		4. DATE OF DEATH Month 4 Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-69
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Government Print.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Hixson		14. MOTHER'S MAIDEN NAME Harriett Hickerson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Larkin (son)		Address Cincinnati, Ohio	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent Bilateral Bronchopneumonia - DUE TO Pneumonia - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Congestive Myocardial Failure DUE TO One month (c) Hypertensive Cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to April 26, 1957 , that I last saw the deceased alive on April 25, 1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St Wash 15-D.C. DATE SIGNED 4-26-57			
ACTUAL SIGNATURE Stewart Clapp M.D.		PHYSICIAN'S NAME (Type) Stewart Clapp	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/57	22c. NAME OF CEMETERY OR CREMATORY Manassas	22d. LOCATION (City, town, or county) (State) Manassas, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-26-57 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is faint and mostly illegible.

BUREAU V. S.

APR 29 1957

RECEIVED

Robert A. Humphrey - Baltimore, Md.
4/30/57
Mansions

4179

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE ----- b. COUNTY -----		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN 1b 3 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle Brandt Last Latimer			4. DATE OF DEATH Month April Day 2 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-83		9. AGE (In years last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor--Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Latimer		14. MOTHER'S MAIDEN NAME Mary Beasant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of duodenal ulcer 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) ----- (Exsanguination) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH Terminal
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 , to April 2, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 4:40 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Robert A. Hare		M.D. Takoma Park, Md.		DATE SIGNED 4/2/57	
PHYSICIAN'S NAME (Type) Robert A. Hare					
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-5-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium - Wash. D.C.	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE J. W. T. Son's Co. 300 4th N.E. Wash. D.C.			
24a. REC'D BY REGISTRAR APR 4 1957		24b. REGISTRAR'S SIGNATURE J. T. Hare			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

APR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04257

4274

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>2803-Sheaton Sh.</i>	
3. NAME OF DECEASED (Type or print) <i>Steve Edwards</i> First Middle Last		4. DATE OF DEATH <i>April 14</i> 1957	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 14, 1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baker</i>	11. BIRTH PLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Chris Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Patricia Tully</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Chris Lawson-Item# 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Peritonitis</i> 756.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intestinal Obstruction, perforated Aulus</i> DUE TO (c) <i>Congenital Malformation</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DEATH CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1957</i> , to <i>1957</i> , that I last saw the deceased alive on <i>April 14</i> , 1957, and that death occurred at <i>10:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Geo Maxwell</i> M.D.		ADDRESS (Street, city or town, state) <i>121 S. Washington St. Rockville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Dr George Maxwell</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/17/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 4-15-57</i>	24b. REGISTRAR'S SIGNATURE <i>Beattie M. Thompson</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1957

RECEIVED

4275

CERTIFICATE OF DEATH

04258

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria 83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS 2959 Sycamore Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Patrick Middle James Last LEONARD			4. DATE OF DEATH Month April Day 16 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 February 1957		9. AGE (In years last birthday) yrs. 2 Months 15 Days 15 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Warren E. Leonard			14. MOTHER'S MAIDEN NAME Johnny Louise Cummins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Warren E. Leonard (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal pneumonia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 12 hrs 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital heart disease					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 9 April 19 57 , to 16 April 19 57 , that I last saw the deceased alive on 16 April 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-17-57					
ACTUAL SIGNATURE Howard A. Pearson M.D.		U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 4-17-57	
24b. REGISTRAR'S SIGNATURE Mary E. Parrell					

2051323XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

042594

4276

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3704 Jeffery St.</u>				d. STREET ADDRESS <u>3704 Jeffery St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Levy</u> Last <u>Levy</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-88</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Lewis Levy</u>				14. MOTHER'S MARRIED NAME <u>Rachel Greenbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ruth Greenbaum Same as Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschat</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschat</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deerfield Israel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Dedham Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kaugansky & Sons</u>				ADDRESS <u>3501 14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>44/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Potter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM		AUTOPSY		HISTOLOGY		PATHOLOGY	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		CITY		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.		RECEIVED		DATE		TIME	

RECEIVED
 APR 8 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4277

CERTIFICATE OF DEATH

Reg. Dist. No. 216

04260

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detroit 59x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 19366 Indiana	
3. NAME OF DECEASED (Type or print) ANNA First K. Middle LEWIS Last		4. DATE OF DEATH Month 4 Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-79
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME MOSES KALVER		14. MOTHER'S MAIDEN NAME ETTA WINSBERG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter Address Detroit, Michigan		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Acute fulminant atheroma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1957 to April 24, 1957 , that I last saw the deceased alive on April 24, 1957 , and that death occurred at 3:10 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert H. Coale		ADDRESS (Street, city or town, state) 4630 Montgomerie Ave., Bethesda, Md	
PHYSICIAN'S NAME (Type) ROBERT N. COALE		DATE SIGNED 4/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 26, 1957	
22c. NAME OF CEMETERY OR CREMATORY GRANDVIEW		22d. LOCATION (City, town, or county) (State) JOHNSTOWN P. A.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons		ADDRESS 3501-14th St N.W.	
24a. REC'D BY REGISTRAR DATE 4-29-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 28, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>West Virginia</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>Mr. & Mrs. J. K. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

BUREAU V. 5

APR 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04261 214
Reg. Dist. No.

4278

Item 14 Film 0123 4-12-57 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9108 Crosby Rd.</u>		d. STREET ADDRESS <u>318 Tench. Ave. N.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Catherine Linsenmeyer</u>		4. DATE OF DEATH <u>Apr 6 1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Donohue</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Grace Mallon (daughter) Same as #1</u>	
17. INFORMANT <u>Grace Mallon (daughter) Same as #1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee-Bon</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		LOCALITY		HISTORY	
FINDINGS		TESTS		TREATMENT	
SIGNATURE OF EXAMINER		DATE		TIME	
OFFICE		COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
RECEIVED		APR 9 1957		BUREAU V. 1	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04262
214

4279

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		d. STREET ADDRESS <u>2101 Hildarose Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2101 Hildarose Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise Field Lloyd</u>		4. DATE OF DEATH Month Day Year <u>Apr 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mass</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Borzellai Field</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kimball</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bernard L. Lloyd (husband)</u>		Address <u>Same Str 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-19-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans. & Burial</u>		22b. DATE THEREOF <u>4/22/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Melrose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brockton, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>James Patten</u>	

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 042635

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 16172</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>			d. STREET ADDRESS <u>6907 Prince Georges Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Ann</u> Last <u>Lord</u>			4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1957</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1936</u>		9. AGE (In years last birthday) <u>20</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Univ.</u>	11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John L. Lord</u>			14. MOTHER'S MAIDEN NAME <u>Jesse m. Davis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. John L Lord</u>	17. INFORMANT <u>Mr. John L Lord</u> Address <u>Takoma Park, Md. 6907 Prince Georges Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>823X</u> DUE TO <u>Compression & crushing left chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Auto accident (compression between auto and bank)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture pelvis & cervical vertebra</u> INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car involved in auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>12:05 p.m. 4/23/57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River Rd.</u>		20f. (City or town) (County) (State) <u>Glen Echo Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>			24a. REC'D BY REGISTRAR <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>May Parrelly</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

APR 25 1957

RECEIVED

CERTIFICATE OF DEATH

04264

Reg. Dist. No.

214

4281

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unity c. LENGTH OF STAY IN TB life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Unity d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First William Middle Luckett Last Luckett			4. DATE OF DEATH Month April Day 29 Year 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Elijah Gilmore			14. MOTHER'S MAIDEN NAME Mary E. Luckett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Daniel Gaither 605 Stonestreet, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct. 16, 1936 to 4/29/57 , 19 57 , that I last saw the deceased alive on 4/29/57 , 19 57 and that death occurred at 4:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rt. 1, Silver Spring DATE SIGNED Webster Sewell					
ACTUAL SIGNATURE Webster Sewell		M.D. Webster Sewell			
PHYSICIAN'S NAME (Type) Webster Sewell					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/57		22c. NAME OF CEMETERY OR CREMATORY Arlington	
22d. LOCATION (City, town, or county) Arlington, Va.		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR May 7 1957	
24b. REGISTRAR'S SIGNATURE Frances Potter					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

<p>1. NAME OF DECEASED William O. Moore</p>		<p>2. SEX Male</p>		<p>3. RACE Colored</p>		<p>4. DATE OF BIRTH August 17, 1888</p>		<p>5. PLACE OF BIRTH Delaware</p>		<p>6. DATE OF DEATH August 17, 1957</p>		<p>7. PLACE OF DEATH Baltimore, Maryland</p>	
<p>8. CAUSE OF DEATH Heart Disease</p>		<p>9. MANNER OF DEATH Natural</p>		<p>10. SIGNATURE OF PHYSICIAN <i>William O. Moore</i></p>		<p>11. SIGNATURE OF WITNESSES <i>William O. Moore</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>William O. Moore</i></p>		<p>13. SIGNATURE OF DECEASED <i>William O. Moore</i></p>		<p>14. SIGNATURE OF NEXT OF KIN <i>William O. Moore</i></p>	
<p>15. NAME OF NEXT OF KIN William O. Moore</p>		<p>16. ADDRESS OF NEXT OF KIN Baltimore, Maryland</p>		<p>17. RELATIONSHIP TO DECEASED Wife</p>		<p>18. DATE OF MARRIAGE August 17, 1888</p>		<p>19. PLACE OF MARRIAGE Delaware</p>		<p>20. DATE OF DEATH August 17, 1957</p>		<p>21. PLACE OF DEATH Baltimore, Maryland</p>	

BUREAU V. 2

MAY 7 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04265

4282

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5108 Duvall Drive		e. STREET ADDRESS 5108 Duvall Drive	
3. NAME OF DECEASED (Type or print) First Eleanora Middle Luve Last Luve		4. DATE OF DEATH Month April Day 4 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1873
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Lee		14. MOTHER'S MAIDEN NAME Julia Ann Trodden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Marton		Address 5108 Duvall Drive, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) Arteriosclerosis, General and Cerebral 10 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Gangrene Right foot			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1947 to Mar 4, 1957 , that I last saw the deceased alive on Mar 4, 1957 , and that death occurred at 4:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank S. Bacon		M.D. 1150-Cornell DATE SIGNED 11/5/57	
PHYSICIAN'S NAME (Type) Frank S. Bacon			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/6/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. Wash		ADDRESS D.C.	
24a. REC'D BY REGISTRAR 4-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

[illegible]

BUREAU V. S.

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04266
217

Reg. Dist. No.

4283

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Fairland			c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Fairland- Beltsville Rd.				d. STREET ADDRESS 12903 Parkland Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Leo Francis Mangan				4. DATE OF DEATH Month April Day 2 Year 1957		19		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/15		
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George P. Mangan		
14. MOTHER'S MAIDEN NAME Rose Melling		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Police Records		17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO bullet wound in rt. skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 976x DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Pending		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 22 ca. rifle while in car						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4/1/57 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods		20f. (City or town) (County) (State) nr Fairland Montg Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/2/57				DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Frank Geiers Sons Co				24a. REC'D BY REGISTRAR APR 3 1957				
ADDRESS 3605-14 St NW Wash DC				24b. REGISTRAR'S SIGNATURE Gertrude Lowrey				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, occupation, and date of death. The form is partially filled out with handwritten and typed text.

BUREAU V. 3

APR 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04267

7/23

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b II Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City 67X-3		d. STREET ADDRESS 2540 Hudson Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie		Middle (MMN)		Last Margolis		4. DATE OF DEATH Month April		Day 26		Year 1957		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-97		9. AGE (In years last birthday) 59		10. IF UNDER 1 YEAR Months 4		Days 26		Hours 19		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey N.Y.		12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Henry Alback		14. MOTHER'S MAIDEN NAME Otilla Mohr		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lips - fibros - sarcoma 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) metastatic DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 4 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 4/14/57 , 19 57 , to 4/26/57 , 19 57 , that I last saw the deceased alive on 4/26/57 , 19 57 , and that death occurred at 325A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Wash. Sub.		DATE SIGNED Wash. Sub.		ACTUAL SIGNATURE Raymond O. Weiss		M.D.		PHYSICIAN'S NAME (Type) Wash. Sub.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Jersey City Cem		22d. LOCATION (City, town, or county) Jersey City, NJ		22e. (State) NJ		23. FUNERAL DIRECTOR'S SIGNATURE Wash. Sub.		ADDRESS 4812 Georgia Ave NW		24a. REC'D BY REGISTRAR APR 30 1957	
24b. REGISTRAR'S SIGNATURE Wash. Sub.		24c. (City, town, or county) Wash. Sub.		24d. (State) Wash. Sub.		24e. (Country) Wash. Sub.		24f. (City, town, or county) Wash. Sub.		24g. (State) Wash. Sub.		24h. (Country) Wash. Sub.		24i. (City, town, or county) Wash. Sub.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-56

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF CORONER	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF OTHER		17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
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97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. 3

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04268

Reg. Dist. No. 218

4284

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 N. Frederick Ave.</u>				d. STREET ADDRESS <u>106 N. Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janet Sue Marsee</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/28/1957</u>		9. AGE (In years last birthday) yrs. <u>26</u>	IF UNDER 1 YEAR Months <u>26</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bill Marsee</u>				14. MOTHER'S MAIDEN NAME <u>Verda Fitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mother Same as Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to vomitus</u> <u>475x</u> DUE TO <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Upper Respiratory Infection</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		4/24/57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middlesboro, Cemetery Middlesboro Kentucky</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>				24a. REC'D BY REGISTRAR <u>4-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Verda G. Cook</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2074212XV4

RECEIVED

APR 30 1957

BUREAU V. 2

4181

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>7 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Evelyn</i> Middle <i>Evangelina</i> Last <i>McCalley</i>				4. DATE OF DEATH Month <i>4</i> Day <i>3</i> Year <i>1957</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-17-82</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Va.</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>	
13. FATHER'S NAME <i>Presley Balderson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Coates</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Washington Sanitarium & Hospital Records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> 420.1 DUE TO (b) <i>Infarct of the myocardium</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260X</i> DUE TO (c) <i>Diabetes mellitus + Recurrent bilateral pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 210. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 220. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 230. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i>1957</i> 240. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 250. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 260. (City or town) (County) (State) 270. I certify that I attended the deceased from <i>April 3, 1957</i> to <i>April 3, 1957</i> that I last saw the deceased alive on <i>April 3, 1957</i> , and that death occurred at <i>2:21 P.M.</i> from the causes and on the date stated above. 280. ACTUAL SIGNATURE <i>Sydney Leventhal</i> M.D. <i>9210 Coleville Rd, Silver Spring, Md.</i> DATE SIGNED <i>4/3/57</i> 290. PHYSICIAN'S NAME (Type) <i>SYDNEY LEVENTHAL</i> 300. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 310. DATE THEREOF <i>April 6, 1957</i> 320. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i> 330. LOCATION (City, town, or county) (State) <i>Montgomery County, Md.</i> 340. FUNERAL DIRECTOR'S SIGNATURE <i>L. Arthur Walters</i> ADDRESS <i>254 Carroll Pl. NW, DC.</i> 350. REC'D BY REGISTRAR <i>APR 5 - 1957</i> 360. REGISTRAR'S SIGNATURE <i>William Dock</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. PLACE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF HEALTH DEPARTMENT		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF MARSHAL	
25. SIGNATURE OF SHERIFF'S DEPUTY		26. SIGNATURE OF MARSHAL'S DEPUTY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY FOREMAN		29. SIGNATURE OF JURY CLERK		30. SIGNATURE OF JURY MEMBER	
31. SIGNATURE OF JURY MEMBER		32. SIGNATURE OF JURY MEMBER		33. SIGNATURE OF JURY MEMBER	
34. SIGNATURE OF JURY MEMBER		35. SIGNATURE OF JURY MEMBER		36. SIGNATURE OF JURY MEMBER	
37. SIGNATURE OF JURY MEMBER		38. SIGNATURE OF JURY MEMBER		39. SIGNATURE OF JURY MEMBER	
40. SIGNATURE OF JURY MEMBER		41. SIGNATURE OF JURY MEMBER		42. SIGNATURE OF JURY MEMBER	
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97. SIGNATURE OF JURY MEMBER		98. SIGNATURE OF JURY MEMBER		99. SIGNATURE OF JURY MEMBER	
100. SIGNATURE OF JURY MEMBER		101. SIGNATURE OF JURY MEMBER		102. SIGNATURE OF JURY MEMBER	

BUREAU V. R.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04270

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2½ yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,021 RENFREW ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KIM Middle EDWARD Last McCARREN				4. DATE OF DEATH Month APRIL Day 18 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 14, 1950	
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 18		IF UNDER 24 HRS. Hours 18 Min. 1957			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) BOSTON, MASS.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN F. McCARREN				14. MOTHER'S MAIDEN NAME DOLORES J. JASPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. John F. McCarren, 10,015 Renfrew Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) accidental head and neck injury (c) neck injury DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck left upper neck by baseball while playing							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck left upper neck by baseball while playing			
20c. TIME OF INJURY Month, Day, Year 3:30 p. m. April 18 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Silver Spring, Montgomery, Md.				20g. (County) MONTGOMERY			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/20/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 4/25/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4182

CERTIFICATE OF DEATH

Reg. Dist. No.

04271

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7300 Baltimore Avenue</u>				d. STREET ADDRESS <u>47X-3 310-2nd St NE</u>			
3. NAME OF DECEASED (Type or print) <u>First Sarah Middle AGNES MC.CREADY Last</u>				4. DATE OF DEATH <u>April 24 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. U.S. Post</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Mc Cready</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth F. Delanty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>E. R. Nelson</u>		Address <u>Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tofemia + hemorrhage</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis</u> DUE TO (c) <u>Cancer of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>6 mos.</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct 9 1957</u> , to <u>Apr 27 1957</u> , that I last saw the deceased alive on <u>Apr 23 1957</u> , and that death occurred at <u>3:57 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. S. Crisp</u>				ADDRESS (Street, city or town, state) <u>501-8th St NE</u>			
DATE SIGNED <u>Apr 24 1957</u>							
PHYSICIAN'S NAME (Type) <u>E. S. Crisp M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Cem. Washington - DC</u>		22d. LOCATION (City, town, or county) (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>J. Wilson Dodd</u>	
DATE <u>4/26/57</u>				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

BUREAU V. 3

APR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04272

4285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Chevy Chase		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6313 Broad Branch Rd.				d. STREET ADDRESS 6313 Broad Branch Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Galbraith Last McGraw				4. DATE OF DEATH Month Apr. Day 13, Year 1957 19				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1888		
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 8 Days 8		IF UNDER 24 HRS. Hours 8 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY Auto Mechanic		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas McGraw				14. MOTHER'S MAIDEN NAME Ellen Hayes				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1 577-20-0687		17. INFORMANT Helen Herzog(sister) Address Same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-15-57				22b. DATE THEREOF 4-15-57		22c. NAME OF CEMETERY OR CREMATORY St. James Church Cem.		
22d. LOCATION (City, town, or county) Naugatuck, Conn.				22e. (State) Conn.				
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-15-57		
24b. REGISTRAR'S SIGNATURE Beaie M. Thompson				DATE SIGNED 4/13/57				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 9 Film 215 5-17-57 et
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
4287
CERTIFICATE OF DEATH

04273

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				c. LENGTH OF STAY IN 1b 2yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie McPhee				4. DATE OF DEATH Apr 12 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 23-1885 101 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James McCoy				14. MOTHER'S MAIDEN NAME Elizabeth Rosenberry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address The Marylander Records, Germantown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 17, 1955 , to April 12, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at Md , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thomasboro, Md. DATE SIGNED 4/13/57							
ACTUAL SIGNATURE James P. Kerr				M.D. Thomasboro, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Washington, Suitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner ADDRESS Gaithersburg, Md.				24a. REC'D BY REGISTRAR Apr 16-57		24b. REGISTRAR'S SIGNATURE Abraham J. Cooke	

4288

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1010 Quebec Terrace				d. STREET ADDRESS 142 Moredale Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle A. Last METTING				4. DATE OF DEATH Month APRIL Day 25 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - OWN HOME				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN J. GALLAGHER				14. MOTHER'S MAIDEN NAME EMMA A. FROEHLICH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. Wm. E. Metting, 1010 Quebec Terrace, Apt. 103 Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Massive Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 21, 1956 , to April 25, 1957 , that I last saw the deceased alive on April 24, 1957 , and that death occurred at 6:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 113 Carroll St NW DATE SIGNED 4/26/57 ACTUAL SIGNATURE Dean H. Harding M.D. PHYSICIAN'S NAME (Type) Dean H. Harding, M. D. 113 Carroll Street, N. W., Washington D. C.							
22a. BURIAL, CREMATION, REMOVAL, (Specify) TRANS. & BURIAL				22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY ZIMMERMANN CEMETERY	
22d. LOCATION (City, town, or county) (State) PITTSBURGH, PENNSYLVANIA							
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/29/57	
24b. REGISTRAR'S SIGNATURE Francis Potter							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. BROCHART		45		M		W		JAN 10 1957		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1000 E. CALHOUN ST.		DRIVER		HEART DISEASE		NATURAL		1000		YES	
FATHER		MOTHER		BIRTH		EDUCATION		MARRIAGE		RELIGION	
JAMES J. BROCHART		JANE J. BROCHART		JAN 10 1912		HIGH SCHOOL		MAY 10 1935		CATHOLIC	
BROTHER		SISTER		DECEASED		DECEASED		DECEASED		DECEASED	
JAMES J. BROCHART		JANE J. BROCHART		JAN 10 1912		HIGH SCHOOL		MAY 10 1935		CATHOLIC	

Dr. Broschart was notified by telephone and he stated he would approve
Dean H. Harding

RECEIVED
MAY 1 1957
BUREAU V. F.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4289 CERTIFICATE OF DEATH

04275
217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16152</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>4504 Burlington Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Cecile Michael</u>				4. DATE OF DEATH <u>April 24 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20 - 1897</u>	
				9. AGE (In years last birthday) <u>59 yrs.</u>		IF UNDER 1 YEAR: Months <u>9</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Clayton M. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Myra Beatty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Myron Michael - Husband</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEBILITY - MALIG. OF LEFT</u> <u>142.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PAROTID GLAND = METAST.</u> DUE TO (c) <u>TO BRAIN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 5, 1956</u> , to <u>Apr. 24, 1957</u> , that I last saw the deceased alive on <u>April 14, 1957</u> , and that death occurred at <u>10:58 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John B. Zeigler</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>APR 25 1957</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Certitude Lumbert</u>			

CERTIFICATE OF DEATH

1957

PLACE OF BIRTH		MARRIAGE	
BALTIMORE, MD		MARRIED	
DATE OF BIRTH		DATE OF MARRIAGE	
JANUARY 1, 1910		JANUARY 1, 1910	
AGE		AGE	
47 YEARS		47 YEARS	
SEX		SEX	
FEMALE		FEMALE	
RACE		RACE	
WHITE		WHITE	
EDUCATION		EDUCATION	
HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		OCCUPATION	
HOUSEWIFE		HOUSEWIFE	
CAUSE OF DEATH		CAUSE OF DEATH	
CORONARY DISEASE		CORONARY DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
DATE OF DEATH		DATE OF DEATH	
JANUARY 1, 1957		JANUARY 1, 1957	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF REPORT		DATE OF REPORT	
JANUARY 1, 1957		JANUARY 1, 1957	
REPORTED BY		REPORTED BY	
J. J. JONES		J. J. JONES	
SIGNATURE		SIGNATURE	
J. J. JONES		J. J. JONES	
TITLE		TITLE	
PHYSICIAN		PHYSICIAN	
HOSPITAL		HOSPITAL	
BALTIMORE, MD		BALTIMORE, MD	

BUREAU V. S.

APR 29 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4290

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle N Last Miller				4. DATE OF DEATH Month April Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1882	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Clerk-Retired		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jones T. Miller				14. MOTHER'S MAIDEN NAME Emma Whitlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT William J. Miller		Address 9314 Georgetown Rd., Beth. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Mitral Disease, Stenosis DUE TO (c) Astherosclerosis Coronary						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Astherosclerosis Coronary						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1954 , to date , 19 57 , that I last saw the deceased alive on 13 April , 19 57 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd. Bethesda, Md. DATE SIGNED Apr. 13, 1957							
ACTUAL SIGNATURE John G. Ball M.D.				PHYSICIAN'S NAME (Type) JOHN G. BALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR 4-15-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
David		Male		11		1911		Maryland	
Occupation		Cause of Death		Date of Death		Place of Death		Time of Death	
Student		Heart Disease		April 1, 1957		Baltimore, Md.		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

40-2620-100

BUREAU V. S.

APR 17 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Medley</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-27-79</u> 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hatchery</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Moore</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart (W.S.H.)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emaciation</u> 730.1 DUE TO (b) <u>Osteomyelitis - Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>40 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteogenic Sarcoma at site of old Osteo</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4/18/57</u> to <u>4/19/57</u> , 1957, that I last saw the deceased alive on <u>4/18/57</u> , 1957, and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.				ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				DATE SIGNED <u>4/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Sartorius</u>				ADDRESS <u>Gaithersburg, Md.</u>		24. REC'D BY REGISTRAR <u>APR 23 1957</u>	
				25. REGISTRAR'S SIGNATURE <u>J. Wilson Doherty</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1957

RECEIVED

4291

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b 50 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				d. STREET ADDRESS 4725 Cumberland Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4725 Cumberland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle R Last MOORE				4. DATE OF DEATH Month April Day 18 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1872		9. AGE (In years last birthday) yrs. 84	IF UNDER 1 YEAR Months 7 Days 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Waynesville, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett Roberts				14. MOTHER'S MAIDEN NAME Sarah Kellen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Margaretta Vogt-4303 Curtis Rd. Chevy Ch. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Congestive Heart failure DUE TO (b) Coronary artery Disease DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 years 6 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 57 , to April 18 , 19 57 ; that I last saw the deceased alive on 12:30 PM 4-18-57 , and that death occurred at 4:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Vernon S. Martens M.D.				ADDRESS (Street, city or town, state) Germantown, Maryland DATE SIGNED 4-18-57			
PHYSICIAN'S NAME (Type) Vernon S. Martens, M.D.							
22a. BURIAL, CREMATION, REMOVAL, SPECIFY Burial		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY Miami Cemetery		22d. LOCATION (City, town, or county) (State) Waynesville Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md				24a. REC'D BY REGISTRAR DATE 4-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VISIONING

Dr. J. C. D.

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BUREAU V. 5

APR 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04279

4292

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kesmor Sanitarium 5221 Massachusetts Ave. Bethesda Md</u>				d. STREET ADDRESS <u>321 Farragut St. N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JAKE</u> First <u>Hyman</u> Middle <u>Mossman</u> Last				4. DATE OF DEATH <u>April</u> Month <u>22</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>unknown - Benjamin</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>77-44-0962</u>			
17. INFORMANT <u>wife</u> Address <u>321 Farragut St. N.W.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dehydration</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinomatosis</u> DUE TO (c) <u>carcinoma of rectum</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 9</u> , 19 <u>57</u> , to <u>April 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>57</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4861 A Pottery Lane, Bethesda, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Wilfred R. Chremont</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Natl Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>JOHN J. SMITH</i></p>		<p>2. Sex: <i>Male</i></p>		<p>3. Race: <i>White</i></p>	
<p>4. Date of birth: <i>1915</i></p>		<p>5. Place of birth: <i>NEW YORK</i></p>		<p>6. Date of death: <i>1957</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Immediate cause: <i>Myocardial Infarction</i></p>		<p>9. Underlying cause: <i>Coronary Artery Disease</i></p>	
<p>10. Place of death: <i>Home</i></p>		<p>11. Signature of physician: <i>[Signature]</i></p>		<p>12. Signature of registrar: <i>[Signature]</i></p>	
<p>13. Date of registration: <i>1957</i></p>		<p>14. Registrar's name: <i>[Name]</i></p>		<p>15. Registrar's title: <i>[Title]</i></p>	

BUREAU V. S.

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4293

CERTIFICATE OF DEATH

04280

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1, Derwood</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Russell Nursing Home</u>				d. STREET ADDRESS <u>RD 1, Derwood</u>			
3. NAME OF DECEASED (Type or print) <u>EFFIE</u> ^{First} <u>V.</u> ^{Middle} <u>NELSON</u> ^{Last}				4. DATE OF DEATH <u>April</u> ^{Month} <u>23</u> ^{Day} <u>1957</u> ^{Year}			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1901</u>	
9. AGE (In years, last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary J. Prather</u>		Address <u>Derwood, Md. R. F. D. # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic</u> DUE TO (c) <u>Arthritis, ankylosed spine</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, ankylosed spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>56</u> , to <u>4-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-23-57</u> , 19 <u>57</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clive E. Jackson</u>				M.D. <u>RD 1, Gaithersburg, Md.</u> DATE SIGNED <u>4-23-57</u>			
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson, M. D.</u>				<u>RD 1, Gaithersburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove,</u>		22d. LOCATION (City, town, or county) (State) <u>Emory Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworde</u>				ADDRESS <u>Rockville, Md.</u>		24. REC'D BY REGISTRAR <u>APR 23 1957</u> REGISTRAR'S SIGNATURE <u>Alameda G. Cooks</u>	

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04281

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 706 Jefferson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Danial Middle Shirley Last Nichols				4. DATE OF DEATH Month Apr. Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Danial H. Nichols				14. MOTHER'S MAIDEN NAME Shirley McFaden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rita Nichols(wife) Address Same as Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic & Cerebral Hemorrhage DUE TO Crushed chest & Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed chest & Fracture of Skull DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran thru stop sign and struck by another car					
20c. TIME OF INJURY Month, Day, Year 11.00 a.m. 4/5/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8/57		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR 4-8-57		24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Daniel Shilby Nichols		42		Male		White		12/25/1954		706 Jefferson Ave.	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
Baltimore, Md.		Police Officer		Fracture of Skull		Accident		[Signature]		[Signature]	
Date of Birth		Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Autopsy		Date of Burial	
12/25/1912		12/25/1954		12/25/1954		12/25/1954		12/25/1954		12/25/1954	
Place of Birth		Place of Death		Place of Burial		Place of Interment		Place of Cremation		Place of Disposition	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
12/25/1954		12/25/1954		12/25/1954		12/25/1954		12/25/1954		12/25/1954	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
12/25/1954		12/25/1954		12/25/1954		12/25/1954		12/25/1954		12/25/1954	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.		706 Jefferson Ave.	

BUREAU V. 2

APR 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

4184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Levittown</u> 75x-3 ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. & Hospital</u>				d. STREET ADDRESS <u>73 Graystone Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Mr. Karl</u> First <u>Alfons</u> Middle <u>Nordvall</u> Last				4. DATE OF DEATH <u>April</u> Month <u>17</u> Day <u>1957</u> Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-04</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fineand</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Nordvall</u>				14. MOTHER'S MAIDEN NAME <u>Emelina Silander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>wife</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u> 257x DUE TO <u>Brain tumor (cerebellar)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>1 year.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>4-11</u> 19 <u>57</u> , to <u>4-17</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4-17</u> 19 <u>57</u> , and that death occurred at <u>3:30 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Harry H. Ammerman</u> M.D. <u>2025-I. K.B.N.U.</u>				<u>4-17-57</u>			
PHYSICIAN'S NAME (Type) <u>HARRY H. AMMERMAN, M.D.</u>				<u>WASH. G. D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>APR. 19, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEM.</u>		22d. LOCATION (city, town, or county) (State) <u>RIGGS RD. HYATTSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24. BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

APR 22 1957

RECEIVED

4185

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park - Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>16926 Willow St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>OXLEY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>91</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED OXLEY</u>		14. MOTHER'S MAIDEN NAME <u>Mary King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>friend -</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Bronchitis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4/7/57</u> <u>4/10/57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic Pneumonia</u> <u>4 days</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 5, 1956</u> to <u>April 28, 1957</u> that I last saw the deceased alive on <u>April 28, 1957</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>703 Lancaster Ave</u> DATE SIGNED <u>4/28/57</u>	
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		<u>Takoma Park Ind</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 3, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BATTLE CREEK MICH.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Talley</u>		ADDRESS <u>254 GARNETT ST. N.W.</u>	24a. REC'D BY REGISTRAR <u>APR 30 1957</u> DATE
		24b. REGISTRAR'S SIGNATURE <u>John J. Talley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 1 1957

RECEIVED

Handwritten notes and signatures at the bottom of the page, including "RECEIVED" and "MAY 1 1957".

4186 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Ward 1050 Carroll Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Maudie Paden</i>		4. DATE OF DEATH Month <i>Apr</i> Day <i>28</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Oct 13 1867</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i>	
11. BIRTHPLACE (State or foreign country) <i>W Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William J Paden</i>		14. MOTHER'S MAIDEN NAME <i>McClister</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Personal Papers</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>527.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Upper Respiratory Infection</i> delays.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/25</i> , 19 <i>57</i> , to <i>4/27</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/26</i> , 19 <i>57</i> , and that death occurred at <i>A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		ADDRESS (Street, city or town, state) <i>2030 Carroll Ave</i> DATE SIGNED <i>4/28/57</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD T. MORSE</i>		<i>Takoma Park, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>APR 30, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GEORGE WASHINGTON CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE, COUNTY, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Miller</i>		24. REC'D BY REGISTRAR <i>APR 30 1957</i>	
ADDRESS <i>214 Carroll St NW</i>		24b. REGISTRAR'S SIGNATURE <i>J. Wilson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of church		22. Signature of school		23. Signature of business		24. Signature of other	
25. Signature of witness		26. Signature of jury		27. Signature of court		28. Signature of state	
29. Signature of federal		30. Signature of international		31. Signature of universal		32. Signature of world	
33. Signature of universe		34. Signature of everything		35. Signature of all		36. Signature of nothing	
37. Signature of someone		38. Signature of no one		39. Signature of anywhere		40. Signature of nowhere	
41. Signature of when		42. Signature of never		43. Signature of how		44. Signature of why	
45. Signature of what		46. Signature of who		47. Signature of which		48. Signature of whose	
49. Signature of whom		50. Signature of what		51. Signature of which		52. Signature of whose	
53. Signature of whom		54. Signature of what		55. Signature of which		56. Signature of whose	
57. Signature of whom		58. Signature of what		59. Signature of which		60. Signature of whose	
61. Signature of whom		62. Signature of what		63. Signature of which		64. Signature of whose	
65. Signature of whom		66. Signature of what		67. Signature of which		68. Signature of whose	
69. Signature of whom		70. Signature of what		71. Signature of which		72. Signature of whose	
73. Signature of whom		74. Signature of what		75. Signature of which		76. Signature of whose	
77. Signature of whom		78. Signature of what		79. Signature of which		80. Signature of whose	
81. Signature of whom		82. Signature of what		83. Signature of which		84. Signature of whose	
85. Signature of whom		86. Signature of what		87. Signature of which		88. Signature of whose	
89. Signature of whom		90. Signature of what		91. Signature of which		92. Signature of whose	
93. Signature of whom		94. Signature of what		95. Signature of which		96. Signature of whose	
97. Signature of whom		98. Signature of what		99. Signature of which		100. Signature of whose	

RECEIVED
MAY 1 1957
BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04285

Reg. Dist. No.

223

4187

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>Silver Spring 56</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carolyn Diane Painter</u>				4. DATE OF DEATH Month Day Year <u>Apr 20 1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 31, 1952</u>	
9. AGE (in years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>			
13. FATHER'S NAME <u>Harvey Painter</u>				14. MOTHER'S MAIDEN NAME <u>Martha Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT Address <u>Takoma Park</u> <u>Father and Hospital Records.</u> <u>MARYLAND.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia, upper lobes of lung, bilat. 4 or 5 days</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital defect of I.V. septum of heart & pulmonic stenosis (prior valvulotomy)</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>4/20/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadd</u>	

MEDICAL CERTIFICATION

75

I

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

4295

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>V.</u> Last <u>Batterson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mdse. Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY G. Reiter</u>		14. MOTHER'S MAIDEN NAME <u>Kate Reichert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>165-09-2081</u>	
17. INFORMANT Address <u>Eva Thurston, 4600 Drummond Ave. Ch.Ch.Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular disease</u> DUE TO <u>Hypertensive cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>56</u> , to <u>4/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/23</u> , 19 <u>57</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>6306 Wisconsin Ave. Bethesda, Md.</u>		DATE SIGNED <u>4/24/57</u>	
ACTUAL SIGNATURE <u>J. L. Marks</u>		M.D. <u>6306 Wisconsin Ave. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. L. MARKS, M.D.</u>		<u>6306 Wisconsin Ave. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>4/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Peace</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>4-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

APR 29 1957

RECEIVED

COPIES OF THIS CERTIFICATE OF DEATH ARE TO BE FURNISHED TO THE

STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
AT WASHINGTON, D. C. 20460
TO BE USED IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOR THE PURPOSES OF THE NATIONAL CENTER FOR HUMAN RESEARCH
AND THE NATIONAL CENTER FOR HUMAN RESEARCH

4296

CERTIFICATE OF DEATH

04287

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 29 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Washington 47X-3				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			
d. STREET ADDRESS 345 Cedar Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Mary Middle Hazel Last Patton		4. DATE OF DEATH		Month April Day 12 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry (Unknown)				14. MOTHER'S MAIDEN NAME Elizabeth Devore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cerebral Hemorrhage, etc. sub 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pyelonephritis, left side INTERVAL BETWEEN ONSET AND DEATH 4 wks 1 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14 , 19 57 , to April 12 , 19 57 , that I last saw the deceased alive on April 12 , 19 57 , and that death occurred at 11:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 4-13-57							
ACTUAL SIGNATURE R. W. Weiger, M.D.		PHYSICIAN'S NAME (Type) Robert W. Weiger, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Transit Burial		April 16, 1957		Mill Creek Cemetery		Beaver County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carran St NW. N.C.				24a. REC'D BY REGISTRAR APR 15 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

DECEASED: [Name] [Address] [City] [State] [Zip]
DATE OF DEATH: [Date] TIME OF DEATH: [Time] PLACE OF DEATH: [Place]

CAUSE OF DEATH: [Cause] [Code] [Code]
MANNER OF DEATH: [Manner] [Code] [Code]

REPORTED BY: [Name] [Address] [City] [State] [Zip]
DATE OF REPORT: [Date] TIME OF REPORT: [Time] PLACE OF REPORT: [Place]

REGISTRATION NO.: [Number] [Code] [Code]
FILING NO.: [Number] [Code] [Code]

DECEASED'S SIGNATURE: [Signature] [Date] [Time] [Place]
REPORTER'S SIGNATURE: [Signature] [Date] [Time] [Place]

DECEASED'S ADDRESS: [Address] [City] [State] [Zip]
REPORTER'S ADDRESS: [Address] [City] [State] [Zip]

DECEASED'S OCCUPATION: [Occupation] [Code] [Code]
REPORTER'S OCCUPATION: [Occupation] [Code] [Code]

DECEASED'S SEX: [Sex] [Code] [Code]
REPORTER'S SEX: [Sex] [Code] [Code]

DECEASED'S RACE: [Race] [Code] [Code]
REPORTER'S RACE: [Race] [Code] [Code]

BUREAU V. 1

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG214 4-26-57 et

04288-
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old US R-240				d. STREET ADDRESS 924 C St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robie Middle Payne Last				4. DATE OF DEATH Month 4/21/57 Day 19 Year			
5. SEX male	6. COLOR OR RACE ool.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1916		9. AGE (In years, months, and days) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tillman Payne				14. MOTHER'S MAIDEN NAME Hannah Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Pearl Payne Address 924 C Street, N. E. Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 823X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which left highway					
20c. TIME OF INJURY Month, Day, Year 11 Hour 30 min. 4/21/57 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Derwood Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/22/57		22c. NAME OF CEMETERY OR CREMATORY Hall Funeral Home		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Snowden				ADDRESS Rockville, Md.		24. REG'D BY REGISTRAR APR 23 1957	
				24b. REGISTRAR'S SIGNATURE G. H. Hebrich			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. No burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
JAMES EARL RAY		Male		35		White		April 4, 1968		Memphis, Tennessee	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
Memphis, Tennessee		Attorney at Law		Suicide		Suicide		J. Edgar Hoover		J. Edgar Hoover	
Date of Birth		Date of Death		Time of Death		Place of Death		Signature of Examiner		Signature of Coroner	
April 4, 1928		April 4, 1968		4:00 PM		Memphis, Tennessee		J. Edgar Hoover		J. Edgar Hoover	
Date of Birth		Date of Death		Time of Death		Place of Death		Signature of Examiner		Signature of Coroner	
April 4, 1928		April 4, 1968		4:00 PM		Memphis, Tennessee		J. Edgar Hoover		J. Edgar Hoover	

BUREAU V. S.

APR 28 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4298

CERTIFICATE OF DEATH

04289
Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus				c. LENGTH OF STAY IN 1b x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Harry Middle F. Last Pearce				4. DATE OF DEATH Month April Day 5 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Foreman John Hopkins A.P.L.		10b. KIND OF BUSINESS OR INDUSTRY Damascus, Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Pearce				14. MOTHER'S MAIDEN NAME Marian Pear Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-7751		17. INFORMANT G. Chester Pearce, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Exhaustion of the myocardium with generalized metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 26, 1954 to April 5, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 4/8/57							
ACTUAL SIGNATURE James P. Kerr				M.D. Damascus, Md.			
PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE Apr. 8/57	
				24b. REGISTRAR'S SIGNATURE Della M. Burdette			

BUREAU V. S.

APR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as a burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4299

CERTIFICATE OF DEATH

04290

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>2 mos. 25 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington 83X-3</u>		d. STREET ADDRESS <u>1405 N. Scott St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Albert</u> Last <u>PENDERGAST</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Dec. 1902</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Pendergast</u>		14. MOTHER'S MAIDEN NAME <u>Clara Mills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 4-22-21 to 7-24 41)</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Miriam Pendergast (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, rectum with</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized metastasis</u> DUE TO (c) <u>2 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. <u>19</u> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 Jan.</u> , 19 <u>57</u> , to <u>1 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 April</u> , 19 <u>57</u> , and that death occurred at <u>2:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-2-57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> PHYSICIAN'S NAME (Type) <u>D.P. OSBORNE, CDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-2-57</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

RECEIVED

4300

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 3000 39th Street, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Ida Middle Augusta Last PETERSON		4. DATE OF DEATH		Month April Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Feb. 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Sweeden		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Daughter) Rosalie I. Peterson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infection, Myocardium, age undetermined						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 April , 19 57 , to 22 April , 19 57 , that I last saw the deceased alive on 22 April , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 4-23-57							
ACTUAL SIGNATURE R.G. Williams				M.D. U.S. Naval Hospital, Bethesda, Md. 4-23-57			
PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4-24-57		Parklawn Cemetery		Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				24a. REC'D BY REGISTRAR DATE 4-22-57		24b. REGISTRAR'S SIGNATURE May E. Carroll	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4301

CERTIFICATE OF DEATH

04293
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9810 Galtier Suburban</u>		c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Maple Lane Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM WALLACE POOLE</u>		4. DATE OF DEATH Month Day Year <u>April 9 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Montg County employ.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maybnd</u>	
11. BIRTHPLACE (State or foreign country) <u>MS</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Tom Wallace Poole</u>		14. MOTHER'S MAIDEN NAME <u>Wilda Alnutt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mrs Virginia Wallace</u>	
17. INFORMANT <u>2740 Brad Blvd Chevy Chase, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHRONIC MYOCARDITIS</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (c) <u>SENILITY</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 14, 1957</u> , to <u>April 9, 1957</u> , that I last saw the deceased alive on <u>April 9, 1957</u> , and that death occurred at <u>6:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 NORWAY DR. April 9, 1957</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		<u>CHEVY CHASE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillon</u>		ADDRESS <u>Barnesville, Md</u>	
24a. REC'D BY REGISTRAR <u>April 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Egan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4302

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Dist of Col.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4534 Harrison St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Edward Purcell</u>		4. DATE OF DEATH Month Day Year <u>April 5 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>1 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Acct off.</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Purcell</u>		14. MOTHER'S MAIDEN NAME <u>Emma PEED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-12-2464</u>	
17. INFORMANT Address <u>Mrs Mae S. Purcell - Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>13 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>April 5, 1957</u> that I last saw the deceased alive on <u>April 5, 1957</u> and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Kuntz</u>		ADDRESS (Street, city or town, state) <u>3701 Concession Ave. N.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kuntz, M.D.</u>		DATE SIGNED <u>4-5-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Alexandria Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24a. REC'D BY REGISTRAR <u>4-8-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4303

CERTIFICATE OF DEATH

04294

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Fawsett Road Route 3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jesse Middle Marvin Last Robertson				4. DATE OF DEATH Month April Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter and				10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker		11. BIRTHPLACE (State or foreign country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Will Tom Robertson				14. MOTHER'S MAIDEN NAME D. George			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Marguerite L. Robertson Address Same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO (c) Hypertensive Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 10 min 3 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 19 55 to April 6, 19 57 , that I last saw the deceased alive on April 6, 19 57 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1463 Rhode Island Ave NW				DATE SIGNED 4/6/57			
ACTUAL SIGNATURE William Robert Perkins M.D.							
PHYSICIAN'S NAME (Type) William Robert Perkins				Washington D.C.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/57		22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Cheryl Chase Thomas ADDRESS 5183 Winona St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 4-11-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland			c. LENGTH OF STAY IN 1b 89 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights 16X22		
3. NAME OF DECEASED (Type or print) First Thomas Middle Anthony Last Rogato, Jr.			4. DATE OF DEATH Month April Day 6 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1947		9. AGE (In years lost birthday) 9 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas A. Rogato, Sr.			14. MOTHER'S MAIDEN NAME Blanche Kirby		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Septicemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphatic Leukemia DUE TO (c) —					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from January 7 , 19 57 , to April 6 , 19 57 , that I last saw the deceased alive on April 6 , 19 57 , and that death occurred at 1.15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE John Laszlo, M.D.		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) John Laszlo, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-10-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat.	22d. LOCATION (City, town, or county) (State) Arlington Va.		
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee, Son		ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR DATE 9 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

APR 9 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04296

4395

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10737 Colesville Road				d. STREET ADDRESS 10737 Colesville Road			
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE (H) S. ROHRBACH				4. DATE OF DEATH Month Day Year April 23 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1877	
9. AGE (In years lost birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME B. Elihu Harrell				14. MOTHER'S MAIDEN NAME Fannie B. Bradform			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Doris R. Lyons -RFD #3 Box 595X				Address Alexandria, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hyperlensive Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/9/50 , 19 50 , to 4/23 , 19 57 , that I last saw the deceased alive on 4/23 , 19 57 , and that death occurred at 4:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. LEONARDO M.D. 5801-13th St NW				ADDRESS (Street, city or town, state) 5801-13th St NW DATE SIGNED 4/23/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Apr. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery Wash. D.C.	
22d. LOCATION (City, town, or county) (State) Wash. D.C.							
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. ADDRESS 317 Pa. Ave., SE DC3				24a. REC'D BY REGISTRAR 4/25/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HANCOCK		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH May 12, 1957		8. TIME OF DEATH 10:15 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.	
13. SIGNATURE OF REGISTRAR J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		15. SIGNATURE OF FUNERAL HOME J. H. Smith	

BUREAU V. 8

APR 25 1957

RECEIVED

4396 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Chesterfield			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 8101 Halidan Drive			
3. NAME OF DECEASED (Type or print) First Robert Middle Joseph Last Roper, Jr.				4. DATE OF DEATH Month April Day 12 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1947		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months 11 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.		
13. FATHER'S NAME Robert J. Roper, Sr.			14. MOTHER'S MAIDEN NAME Margaret Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO Generalized Hemorrhagic Diathesis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Acute Myelogenous Leukemia (c) Bilateral Pulmonary Edema							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Pulmonary Edema							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1 , 19 57 , to April 12 , 19 57 , that I last saw the deceased alive on April 12 , 19 57 , and that death occurred at 6:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/12/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4/16/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 4-15-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1957

RECEIVED

Virginia

Richmond

Washington National

4/17/1957

100-100000

Robert A. Humphrey-7537 W. Ave. Bethesda, Md.

4397

CERTIFICATE OF DEATH

04298
211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Dickenson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Clintwood 83X-3			
3. NAME OF DECEASED (Type or print) First Lydia Middle Florence Last Rose				4. DATE OF DEATH Month April Day 26 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1878	
9. AGE (In years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Clintwood, Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel French		14. MOTHER'S MAIDEN NAME Emeline Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT George Rose, Damascus, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 22, 1957 , to April 26, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at 5:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.			
DATE SIGNED April 26, 1957				DATE SIGNED April 26, 1957			
PHYSICIAN'S NAME (Type) James P. Kerr				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF April 29, 1957				22c. NAME OF CEMETERY OR CREMATORY Smithridge			
22d. LOCATION (City, town, or county) (State) Stratton, Dickenson Co. Va.				24a. REC'D BY REGISTRAR Wella W. Burdette			
24b. REGISTRAR'S SIGNATURE Wella W. Burdette				24c. REGISTRAR'S SIGNATURE Wella W. Burdette			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 29 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b -			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park				d. STREET ADDRESS 17118-Carroll Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700-Hudson Ave., Takoma Park, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hildegard Middle Ruh Last Ruh				4. DATE OF DEATH Month April Day 4 Year 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/ 1868	
9. AGE (In years last birthday) 88? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cartographer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT W.A. Linthicum-Eig Bldg. Silver Spring, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) senile arteriosclerosis, Generalized DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 60 days. 10-15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 57 , to 4 Apr , 19 57 , that I last saw the deceased alive on 2 April , 19 57 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park DATE SIGNED 4 Apr 1957							
ACTUAL SIGNATURE E. B. QUEEN M.D.							
PHYSICIAN'S NAME (Type) E. B. QUEEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. Washington, D.				24a. REC'D BY REGISTRAR APR 9 1957			
24b. REGISTRAR'S SIGNATURE J. H. Hines							

CERTIFICATE OF DEATH

REG. DIST. NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY		DISEASE OR INJURY	
10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. B.

APR 9 1957

RECEIVED

CERTIFICATE OF DEATH

04300

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 90 days			
d. NAME OF HOSPITAL (If institution, give full name and address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Lulu Last Sayler				4. DATE OF DEATH Month April Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 December 1916		9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months 40	IF UNDER 24 HRS. Days 27 Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Representative		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Burton K. Wheeler				14. MOTHER'S MAIDEN NAME Lulu M. White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-26-6550		17. INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe hypotension & large peripheral H. sounds then 170X DUE TO Cardiac arrest 2 mly to CNS metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic breast Ca to brain, lung, & mediastinum + liver DUE TO mediastinum + liver (c) mediastinum + liver						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 16 mos. 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 27, 19 57 , to April 27, 19 57 , that I last saw the deceased alive on April 27, 19 57 , and that death occurred at 12.35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED Peter D. Olch							
ACTUAL SIGNATURE Peter D. Olch				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Peter D. Olch, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Samuels ADDRESS 1756 Pennsylvania Ave NW, Washington, DC				24a. REC'D BY REGISTRAR 5-2-57		24b. REGISTRAR'S SIGNATURE Benjamin Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK DEPARTMENT OF HEALTH

1957

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BUREAU V. S.

MAY 3 1957

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TO BE OBTAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

43-99

CERTIFICATE OF DEATH

04301

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Schoonover		4. DATE OF DEATH Month Day Year April 2 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/57
9. AGE (In years last birthday) yrs. 7		10. IF UNDER 1 YEAR Months Days Hours Min. 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray Marshall Schoonover		14. MOTHER'S MAIDEN NAME Esther Carolyn Schnee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelastases Lung 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) 5 Hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 Hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 April, 1957 , to 2 April, 1957 , that I last saw the deceased alive on 2 April, 1957 , and that death occurred at 3:05 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. B. Ziegler		ADDRESS (Street, city or town, state) Olney, Md.	
PHYSICIAN'S NAME (Type) J. B. Ziegler		DATE SIGNED 2 April 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3	
22c. NAME OF CEMETERY OR CREMATORY Laytonsville		22d. LOCATION (City, town, or county) (State) Laytonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville, Md.	
24a. REC'D BY REGISTRAR 4-4-57		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

2073333XVI

RECEIVED

4310

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5801 Bent Branch Rd.		d. STREET ADDRESS 5801 Bent Branch Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROL ALTHEA BUSHNELL SCOTT		4. DATE OF DEATH Month Day Year APRIL 16, 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 11, 1916
9. AGE (In years last birthday) yrs. 41		IF UNDER 1 YEAR Months Days 0 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Trenton, N.J.
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME William M. Bushnell		14. MOTHER'S MAIDEN NAME Elizabeth A. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Walter K. Scott-Item # 2	
17. INFORMANT Walter K. Scott-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Intestinal Obstruction DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Carcinomatosis DUE TO GASTRIC CARCINOMA (c) 5 MO. 7 MO.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1957 to April 16, 1957 , that I last saw the deceased alive on April 16, 1957 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Md. 4-16-57 DATE SIGNED ACTUAL SIGNATURE A. J. Brennan M.D. A. J. BRENNAN 4630 Montgomery Ave, Bethesda, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 4/18/57		22b. DATE THEREOF 4/18/57	
22c. NAME OF CEMETERY OR CREMATORY Trenton, New Jersey		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-22-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Shonifson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

043034

4311

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN TB <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>12524 Epping Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida S. Searle</u>				4. DATE OF DEATH Month <u>4</u> Day <u>-10-</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Sterens</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT Address <u>Mrs. Paul J. Stubbs, 12,524 Epping Court</u> <u>Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Antemortem renal disease</u> DUE TO (c) <u>1 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1 Jan.</u> , 1957, to <u>9 Apr.</u> , 1957, that I last saw the deceased alive on <u>9 Apr.</u> , 1957, and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>				ADDRESS (Street, city or town, state) <u>929 Penning Drive Silver Spring, Md.</u>			
M.D. <u>57</u>				DATE SIGNED <u>57</u>			
18. NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS & BURIAL</u>		<u>4/13/57</u>		<u>OSKALOOSA CEMETERY</u>		<u>OSKALOOSA, KANSAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis L. Latta</u>			

BUREAU K. 8

APR 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04304

CERTIFICATE OF DEATH

Reg. Dist. No.

214

4312

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE 16152			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDEN SANITARIUM				d. STREET ADDRESS 3507 NICHOLSON			
3. NAME OF DECEASED (Type or print) First Middle Last (LOUIS) LUIGI SERRA				4. DATE OF DEATH Month Day Year APRIL 14 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1888		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEF		10b. KIND OF BUSINESS OR INDUSTRY HOTEL Retired		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EIDEA SERRA				14. MOTHER'S MAIDEN NAME MARY MORELLO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1-44-11-1111		17. INFORMANT Address ELIO V SERRA 3507 NICHOLSON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure & Coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Jaundice & Cirrhosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 1 month ? 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease - Chronic Renal Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/1 , 19 56 , to 6/14 , 19 57 , that I last saw the deceased alive on 4/7 , 19 57 , and that death occurred at 3:46 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M Trozzo Jr. M.D.				ADDRESS (Street, city or town, state) 1840 Michigan Ave N.E. DC			
PHYSICIAN'S NAME (Type) FRANK M. TROZZO JR M.D.				DATE SIGNED 4/14/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home				ADDRESS 4812 1st Ave N.E. Wash DC		24. REGISTRAR'S SIGNATURE Frances Tatter	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>WILLIAM H. TAYLOR</i>		AGE <i>65</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>April 18, 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		LOCALITY OF DEATH <i>City of Baltimore</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>April 19, 1957</i>		DATE OF SIGNATURE <i>April 19, 1957</i>		DATE OF SIGNATURE <i>April 19, 1957</i>		DATE OF SIGNATURE <i>April 19, 1957</i>	

BUREAU V. S.

APR 19 1957

RECEIVED

4189

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patoma Park</u>				c. LENGTH OF STAY IN 1b <u>3-3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Hospital & Sanitation</u>				d. STREET ADDRESS <u>56 Silver Spring</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Kemper</u> Middle <u>James</u> Last <u>Shiplot</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Shiplot</u>				14. MOTHER'S MAIDEN NAME <u>Martha Shiplot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>		17. INFORMANT Address <u>Mrs. Blanche Shiplot 7913 Piney Branch Rd., SS., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Stomach</u> <u>151X</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Feb. 21, 1957</u> , to <u>Apr. 14, 1957</u> , that I last saw the deceased alive on <u>April 14, 1957</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Willard Camakier, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W., Wash. D.C.</u>			
DATE SIGNED <u>4-14-57</u>							
PHYSICIAN'S NAME (Type) <u>C. WILLARD CAMAKIER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Samlar's Sons Washington</u>				24a. REC'D BY REGISTRAR <u>4/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>William Bell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04306

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4190 Item 14 Film G213 4-12-57 et.

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>14</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>ESTHER</u> Last <u>SIRMAI</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-92</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>
13. FATHER'S NAME <u>Jacob Marmelstein</u>				14. MOTHER'S MAIDEN NAME <u>Marion (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hosp. Record - MR. MORRIS SIRMAI</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschait</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHAIT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4-3-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>4/6/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

4313

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 5505 Sonoma Road			
3. NAME OF DECEASED (Type or print) First Edward Middle Ehrlich Last Smith				4. DATE OF DEATH Month April Day 11 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1885		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Coke Smith				14. MOTHER'S MAIDEN NAME Katherine Kinand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Katherine Warren- 5505 Sonoma Road Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, Acute 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Rheumatic calcific mitral stenosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH few hrs ? years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Confluent bronchopneumonia, both lungs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr. 8, 19 57 to Apr. 11, 19 57 that I last saw the deceased alive on Apr. 11, 19 57 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Gray, Jr.				ADDRESS (Street, city or town, state) 104 Chevy Chase Dr. Chevy Chase 15, Md.			
PHYSICIAN'S NAME (Type) George A. Gray, Jr. M.D.				DATE SIGNED 4/12/57			
22a. BURIAL, CREMATION, Cremation		22b. DATE THEREOF 4/12/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 4-18-56		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert J. Lamprey-Barnes, Inc.
April 1957

RECEIVED

APR 22 1957

BUREAU V. 3

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL

Chevy Chase

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3704 Taylor Street

d. STREET ADDRESS

3704 Taylor Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

HARRY

First

ORLANDO

Middle

SMITH

Last

4. DATE OF DEATH

Month

Day

Year

April 12, 1957

19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Mch 19, 1882

9. AGE (In years last birthday)

75 yrs.

IF UNDER 1 YEAR

Months 0 Days 23

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. USMC

10b. KIND OF BUSINESS OR INDUSTRY

USMC

11. BIRTHPLACE (State or foreign country)

Vermont

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Smith

14. MOTHER'S MAIDEN NAME

?

Slayton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

yes

(If yes, give war or dates of service)

W. W. I

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Lucy W. Smith-Item# 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/12/57

EXAMINER'S NAME (Type)

Frank J. Broschart M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Bur-transit

22b. DATE THEREOF

4/15/1957

22c. NAME OF CEMETERY OR CREMATORY

River Bank

22d. LOCATION (City, town, or county)

Lamoille County Vermont

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

APR 17 1957

Bessie Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

[illegible]

APR 17 1957

RECEIVED

Frank J. Broghart, M.D.

CERTIFICATE OF DEATH

04309

Reg. Dist. No.

216

4315

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Smothers Last Smothers		4. DATE OF DEATH Month April Day 13 Year 1957	
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME MOSES		14. MOTHER'S MAIDEN NAME Victoria Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Corra Davis - 4125 Pliers Mill Rd Kensington, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Heart Failure 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Fibrosis, Arteriosclerosis, Plavicyclic Therapy, etc. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Pyelonephritis & Nephrosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 April, 1957 , to 13 April, 1957 , that I last saw the deceased alive on 12 April, 1957 , and that death occurred at 11:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin L. White		DATE SIGNED 13 April 57	
PHYSICIAN'S NAME (Type) Martin L. White		ADDRESS (Street, city or town, state) 1134 George Ave Sdhd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/57	22c. NAME OF CEMETERY OR CREMATORY ASH MEMORIAL	22d. LOCATION (City, town, or county) (State) SANDY SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Lunnedy		24. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1957

BUREAU V. S.

APR 18 1957

RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH

RECORDS

MASSACHUSETTS

CERTIFICATE OF DEATH

Reg. Dist. No. 215

4316

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>3½ days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria 82x-3</u>				d. STREET ADDRESS <u>613 N. Howard Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Michael</u> Last <u>SNOW</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1957</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Joseph Snow</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Carol Garrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Donald J. Snow (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory failure</u> DUE TO (c) <u>Marked prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 April</u> , 19 <u>57</u> , to <u>28 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 April</u> , 19 <u>57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-29-57</u>							
ACTUAL SIGNATURE <u>John H. Mazur</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John H. Mazur, Lt, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u>				24a. REC'D BY REGISTRAR DATE <u>4-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	

R.A. Humphrey, 7557 Wisconsin Ave., Bethesda, Md.

2051211 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

4317

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2212 Henderson Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Gregory Middle George Last Sorrows				4. DATE OF DEATH Month April Day 1 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 23, 1955		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Sorrows				14. MOTHER'S MAIDEN NAME Margaret J. Summerville			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sympatheticoblastoma epinephrale 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) To dura bones, liver, lymph nodes DUE TO Increased intracranial pressure (c) INTERVAL BETWEEN ONSET AND DEATH 6 months 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 22, 1957 , to April 1, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 9.20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Gurston Goldin M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Gurston Goldin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/3/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-6-57	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04312216

4318

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
3. NAME OF DECEASED (Type or print) First Edward Middle H. Last Spellman				4. DATE OF DEATH 4/26/57 Month 4 Day 26 Year 19			
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/26	9. AGE (In years <small>date of birth</small>) 31 yrs.	IF UNDER 1 YEAR Months 4 Days 26	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Y. Spellman				14. MOTHER'S MAIDEN NAME Lillian Howles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Police Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 9146 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Placing metal ladder against building & contacted high vol. wires			
20c. TIME OF INJURY Month, Day, Year 9:50 a.m. 4/26/57		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodmont Country Club Rockville		20f. (City or town) (County) (State) Rockville Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORY Charles L. Whigham Fun. Home		22d. LOCATION (City, town, or county) (State) Newark, N. J.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR APR 30 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

BUREAU V. 2

APR 30 1957

RECEIVED

4191

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gettysburg 75x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>		d. STREET ADDRESS <i>Route 1 - Box 77</i>	
3. NAME OF DECEASED (Type or print) First <i>LAURA</i> Middle <i>MAE</i> Last <i>STEBBINS</i>		4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-89</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR: Months <i>6</i> Days <i>16</i> Hours <i>19</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Florence Colvin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Old Records - and patient</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> 155X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary Carcinoma gall bladder</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i> <i>1+ years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Subacute retinal and conditio</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/24</i> , 19 <i>57</i> , to <i>4/17</i> , 19 <i>57</i> that I last saw the deceased alive on <i>4/16</i> , 19 <i>57</i> , and that death occurred at <i>10:25</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas H. Wolohin</i>		ADDRESS (Street, city or town, state) <i>7401 Blair Rd NW Washington, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Chas H. Wolohin</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 19, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery Prince George Co. Md.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		24. REC'D BY REGISTRAR <i>APR 19 1957</i>	
ADDRESS <i>254 Carroll St NW</i>		24b. REGISTRAR'S SIGNATURE <i>J. Arthur Walters</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 41213

4192

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton X2</u>			
c. LENGTH OF STAY IN 1b <u>45 MIN.</u>				d. STREET ADDRESS <u>12716 Feldon ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Jay</u> Last <u>STEIN</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-57</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>9</u>		IF UNDER 24 HRS. Days <u>9</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <u>PAUL STEIN</u>				14. MOTHER'S MAIDEN NAME <u>ADELE WHITE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Paul STEIN</u> Address <u>12716 Feldon ST., Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory obstruction</u> <u>SOIX</u> DUE TO <u>Laryngo-tracheo-bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 hr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-12-57</u> , 19 <u>57</u> , to <u>4-21-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>57</u> , and that death occurred at <u>9</u> <u>10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3222 Davenport St. N.W.</u> DATE SIGNED <u>David L. Weinstein</u>							
ACTUAL SIGNATURE <u>David L. Weinstein</u> M.D.							
PHYSICIAN'S NAME (Type) <u>David L. Weinstein</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parlson</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Damansky & Sons</u> ADDRESS <u>3501-14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>4/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>F. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and no event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. TIME OF BIRTH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DISTRICT ATTORNEY		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF VILLAGE CLERK	
25. SIGNATURE OF CITY CLERK		26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF VILLAGE CLERK		28. SIGNATURE OF CITY CLERK	
29. SIGNATURE OF TOWNSHIP CLERK		30. SIGNATURE OF VILLAGE CLERK		31. SIGNATURE OF CITY CLERK		32. SIGNATURE OF TOWNSHIP CLERK	
33. SIGNATURE OF VILLAGE CLERK		34. SIGNATURE OF CITY CLERK		35. SIGNATURE OF TOWNSHIP CLERK		36. SIGNATURE OF VILLAGE CLERK	
37. SIGNATURE OF CITY CLERK		38. SIGNATURE OF TOWNSHIP CLERK		39. SIGNATURE OF VILLAGE CLERK		40. SIGNATURE OF CITY CLERK	
41. SIGNATURE OF TOWNSHIP CLERK		42. SIGNATURE OF VILLAGE CLERK		43. SIGNATURE OF CITY CLERK		44. SIGNATURE OF TOWNSHIP CLERK	
45. SIGNATURE OF VILLAGE CLERK		46. SIGNATURE OF CITY CLERK		47. SIGNATURE OF TOWNSHIP CLERK		48. SIGNATURE OF VILLAGE CLERK	
49. SIGNATURE OF CITY CLERK		50. SIGNATURE OF TOWNSHIP CLERK		51. SIGNATURE OF VILLAGE CLERK		52. SIGNATURE OF CITY CLERK	
53. SIGNATURE OF TOWNSHIP CLERK		54. SIGNATURE OF VILLAGE CLERK		55. SIGNATURE OF CITY CLERK		56. SIGNATURE OF TOWNSHIP CLERK	
57. SIGNATURE OF VILLAGE CLERK		58. SIGNATURE OF CITY CLERK		59. SIGNATURE OF TOWNSHIP CLERK		60. SIGNATURE OF VILLAGE CLERK	
61. SIGNATURE OF CITY CLERK		62. SIGNATURE OF TOWNSHIP CLERK		63. SIGNATURE OF VILLAGE CLERK		64. SIGNATURE OF CITY CLERK	
65. SIGNATURE OF TOWNSHIP CLERK		66. SIGNATURE OF VILLAGE CLERK		67. SIGNATURE OF CITY CLERK		68. SIGNATURE OF TOWNSHIP CLERK	
69. SIGNATURE OF VILLAGE CLERK		70. SIGNATURE OF CITY CLERK		71. SIGNATURE OF TOWNSHIP CLERK		72. SIGNATURE OF VILLAGE CLERK	
73. SIGNATURE OF CITY CLERK		74. SIGNATURE OF TOWNSHIP CLERK		75. SIGNATURE OF VILLAGE CLERK		76. SIGNATURE OF CITY CLERK	
77. SIGNATURE OF TOWNSHIP CLERK		78. SIGNATURE OF VILLAGE CLERK		79. SIGNATURE OF CITY CLERK		80. SIGNATURE OF TOWNSHIP CLERK	
81. SIGNATURE OF VILLAGE CLERK		82. SIGNATURE OF CITY CLERK		83. SIGNATURE OF TOWNSHIP CLERK		84. SIGNATURE OF VILLAGE CLERK	
85. SIGNATURE OF CITY CLERK		86. SIGNATURE OF TOWNSHIP CLERK		87. SIGNATURE OF VILLAGE CLERK		88. SIGNATURE OF CITY CLERK	
89. SIGNATURE OF TOWNSHIP CLERK		90. SIGNATURE OF VILLAGE CLERK		91. SIGNATURE OF CITY CLERK		92. SIGNATURE OF TOWNSHIP CLERK	
93. SIGNATURE OF VILLAGE CLERK		94. SIGNATURE OF CITY CLERK		95. SIGNATURE OF TOWNSHIP CLERK		96. SIGNATURE OF VILLAGE CLERK	
97. SIGNATURE OF CITY CLERK		98. SIGNATURE OF TOWNSHIP CLERK		99. SIGNATURE OF VILLAGE CLERK		100. SIGNATURE OF CITY CLERK	

BUREAU V. S.
APR 26 1957

RECEIVED

4319

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 25 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle H. Last Stimek		4. DATE OF DEATH Month April Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-82
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Srigatis		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT Joseph Stimek -- as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mos 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 April , 19 57 , to 10 April , 19 57 , that I last saw the deceased alive on 10 April , 19 57 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. S. Humphrey		DATE SIGNED 6:15 W. Humphrey Rockville, Md. 10 April 1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/15/57	Holy Redeemer Com	4430 Belair Rd.
23. FUNERAL DIRECTOR'S SIGNATURE X John J. Cowan		24a. REC'D BY REGISTRAR APR 12 1957	
ADDRESS 201 St. Hollins		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4320

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE (D. C.) Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 209 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Paul Last Sullivan		4. DATE OF DEATH Month April Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1917
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 15 Hours 48 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Sullivan		14. MOTHER'S MAIDEN NAME Anne Raynor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Not Available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embryonal cell carcinoma, metastatic DUE TO (c) to lungs, kidneys, lymph nodes		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 15 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 5, 1956 , to April 2 , 1957, that I last saw the deceased alive on April 2 , 1957, and that death occurred at 2:15 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE William J. Pieper M.D.		DATE SIGNED 4/2/57	
PHYSICIAN'S NAME (Type) William J. Pieper, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bessie M. Thompson	
ADDRESS Bethesda, Maryland		DATE 4-3-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2320

DEPARTMENT OF HEALTH

State of New York

County of New York

City of New York

Decedent's Name

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Date of Birth

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

BUREAU V. S.

APR 5 1957

RECEIVED

4193

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San and Hospital				d. STREET ADDRESS 608 Forest Glen Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Myrtle Middle Louise Last Swain				4. DATE OF DEATH Month April Day 27 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 3 Days 3 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Columbus, Neb.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Parker				14. MOTHER'S MAIDEN NAME Mary Louise ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Katherine Kearns 608 Forest Glen Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma lung DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1957 , to April 27, 1957 , that I last saw the deceased alive on 4-27 , 19 57 , and that death occurred at 10:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lisidore Shulman M.D.				ADDRESS (Street, city or town, state) 915-19th St. NW.		DATE SIGNED 4-28-57	
PHYSICIAN'S NAME (Type) LISIDORE SHULMAN				Week 6-20			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		22d. LOCATION (City, town, or county) (State) Prince Geo. Co, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Werner E. Humphrey				ADDRESS Silver Spring Md		24a. REC'D BY REGISTRAR APR 30 1957	
				24b. REGISTRAR'S SIGNATURE Werner E. Humphrey			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04318
214

Reg. Dist. No.

4321

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2410 Larrow St.</u>				d. STREET ADDRESS <u>12410 Larrow St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Abner</u> Last <u>Teate</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25 1894</u>	
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Fla</u>			11. BIRTHPLACE (State or foreign country) <u>Fla</u>	
13. FATHER'S NAME <u>FRANCIS ABNER TEATE</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE E. (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-05-6829</u>		17. INFORMANT <u>Frank Teate (son)</u> Address <u>Kennington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>4/5/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to fading and bleed-through from the reverse side.

BUREAU V. 1

APR 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04319

4191

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>				e. STREET ADDRESS <u>18604 Mayfair Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Albert</u> Last <u>Theodore</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Marine Corp</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>La</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Emil Theodore</u>				14. MOTHER'S MAIDEN NAME <u>Clarisse Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>WW #1 and WW #2 217-28-8440</u>		17. INFORMANT <u>Hosp Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage (nt. side)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 7, 1953</u> , to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>10:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr. Silver Spring, Md.</u>		DATE SIGNED <u>4-6-57</u>	
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 90th St. S.S. Md</u>				24a. REC'D BY REGISTRAR DATE <u>4/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04320

4322

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>712 "F" St., S.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Victoria</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 Nov. 1953</u>
9. AGE (In years lost birthday) <u>3</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Francis Xavier Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Gloria Sparrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Francis X. Thompson, (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>subacute glomerulonephritis</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lipoid nephrosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute pancreatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Jan. 1957</u> , 19 <u>57</u> , to <u>12 April</u> , 19 <u>57</u> , that I lost saw the deceased olive on <u>12 April</u> , 19 <u>57</u> , and that death occurred at <u>8:20A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard A. Pearson</u> M.D.		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-13-57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD A. PEARSON, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Bacon</u>		24a. REC'D BY REGISTRAR DATE <u>4-12-57</u>	
ADDRESS <u>Wash. D.C.</u> <u>W.H. Bacon Funeral Home, 1722 7th St., N.W.,</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	

W.H. Bacon 1722-7th St NW

CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years and months)		RACE (Print race)	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
DATE OF DEATH (Month, day, year)		PLACE OF DEATH (City, State, Country)	
TIME OF DEATH (Hour, minute)		CAUSE OF DEATH (List cause of death)	
MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Unknown)		SIGNATURE OF DECEASED (If known)	
SIGNATURE OF WITNESS (If known)		SIGNATURE OF PHYSICIAN (If known)	
SIGNATURE OF CLERK (If known)		SIGNATURE OF REGISTRAR (If known)	

BUREAU V. 1
APR 15 1957

RECEIVED

4195

CERTIFICATE OF DEATH

04321

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cora Middle Lafolia Last Van Gasken				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-72	9. AGE (In years last birthday) yrs. 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Homemaker		11. BIRTHPLACE (State or foreign country) Penna.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James Seitzinger				14. MOTHER'S MAIDEN NAME Hannah Ebert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden acute heart disease 537 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 94.0 (b) Bronchial pneumonia DUE TO (c) Persistent drainage from ruptured heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip Dissected gland							INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 48 hrs. 2 1/2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Hip collapsed and patient fell					
20c. TIME OF INJURY Month, Day, Year Hour 5 am. 3-15-57 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Md. Md.	
21. I certify that I attended the deceased from June 1948 to April 2, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John S. Rogers M.D.				DATE SIGNED 4-2-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/5/57		22c. NAME OF CEMETERY OR CREMATORY SHAMOKIN CEMETERY		22d. LOCATION (City, town, or county) (State) SHAMOKIN, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Murphy				ADDRESS 8434 40 Ave		24a. RECEIVED BY REGISTRAR APR 5 - 1957	
				24b. REGISTRAR'S SIGNATURE J. M. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 8 1957

BUREAU V. S.

*D. H. Buschert
not filed and
sealed.
S. R.*

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 214										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14720 Colesville Rd.					d. STREET ADDRESS Colesville Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Anne Middle Wilhelmina Last Veith					4. DATE OF DEATH Month April Day 5 Year 1957					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/1898		9. AGE (In years last birthday) 58 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Emil Robemacher					14. MOTHER'S MAIDEN NAME Anna Scoffel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Adolph Veith(husband) Same as Item 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 973.1 DUE TO Carbon monoxide poisoning - suicide Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Found dead in car in closed garage								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead on front seat of car in closed garage							
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 4/6/57					
EXAMINER'S NAME (Type) Fra nk J. Broschart ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/9/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey,					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE Frances Peller	

ARMY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

• *not*

14780 COLLEGE RD.

BUREAU V. S.

APR 10 1957

RECEIVED

4324

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery Co.</i> <i>Cedarcroft San 9 Hosp.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>3040 Idaho Ave. N.W.</i> b. COUNTY <i>Washington, D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Md</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedarcroft San 9 Hosp.</i>		d. STREET ADDRESS <i>47X-3</i>	
3. NAME OF DECEASED (Type or print) <i>Harold B. Vollrath</i>		4. DATE OF DEATH Month <i>April</i> Day <i>14</i> Year <i>1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 26-1896</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>1</i> Days <i>19</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chemical engineer (retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred J. Vollrath</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie Benson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Admission Card record</i>	
17. INFORMANT <i>Admission Card record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio Vascular Sclerotic disease</i> (c) <i>also was psychotic-hypomanic type</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <i>Coronary heart disease. Had coronary infarction</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr 10, 1957</i> to <i>Apr 14, 1957</i> , that I last saw the deceased alive on <i>Apr 14</i> , 1957, and that death occurred at <i>12:02 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Alvin J. Kistler</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Cedarcroft San 9 Hosp. 4-14-57</i> <i>Silver Spring Md.</i>	
PHYSICIAN'S NAME (Type) <i>Alvin J. Kistler, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Apr 17/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Samuels</i>		24a. REC'D BY REGISTRAR DATE <i>4-25-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Frances Peller</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

APR 29 1957

RECEIVED

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4325

CERTIFICATE OF DEATH

04324

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Thad.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 35 days 13 hrs. 15	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1 5415 Connecticut Ave., N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Max L. Waeber		4. DATE OF DEATH 4-28-1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1883
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect	
11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.-Naturalized.	
13. FATHER'S NAME ? Waeber		14. MOTHER'S MAIDEN NAME ? Lang	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wife		Address Elizabeth S. Waeber Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon & Metastases to liver & lungs. DUE TO (c) Lungs.			INTERVAL BETWEEN ONSET AND DEATH 4/11 8 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular disease - and Parkinson Disease -			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov - , 19 34 , to date , 19 57 , that I last saw the deceased alive on April 26 , 19 54 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd. Bethesda, Md. DATE SIGNED 29 April 57			
ACTUAL SIGNATURE John G. Ball		M.D. John G. Ball, M.D.	
PHYSICIAN'S NAME (Type)		22c. NAME OF CEMETERY OR CREMATORY Rock Creek	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR 5-2-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Shornfean		24c. LOCATION (City, town, or county) (State) Washington D.C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04325

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4326

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San</u>		d. STREET ADDRESS <u>4121 Military Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Katharine</u>		4. DATE OF DEATH <u>4 - 8 - 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-'64</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Jane Sedgwick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. K. Burr Ellinger</u> daughter <u>W06-3197</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe coronary sclerosis</u> DUE TO (c) <u>Advanced arteriosclerosis & senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 yrs.</u> <u>5 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>April 8, 1957</u> , that I last saw the deceased alive on <u>3-28-1957</u> , and that death occurred at <u>5:49 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>4-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/10/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Lewinsville Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Lewinsville, Fairfax Cty. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Brooks</u>		ADDRESS <u>3034 M St. N.W., D.C.</u>	
24a. REC'D BY REGISTRAR <u>4-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED MORRIS J. DUNN		AGE 47		SEX Male		RACE White	
DATE OF DEATH April 12, 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		UNDERLYING CAUSE Atherosclerosis	
DATE OF BIRTH March 28, 1910		PLACE OF BIRTH Baltimore		CITY Baltimore		COUNTY Baltimore	
FATHER'S NAME John J. Dunn		MOTHER'S NAME Mary E. Dunn		FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Homemaker	
DECEASED'S SIGNATURE Morris J. Dunn		WITNESSES John J. Dunn, Mary E. Dunn		PHYSICIAN'S SIGNATURE Dr. J. H. Smith		HOSPITAL None	
REGISTRAR'S SIGNATURE J. H. Smith		DATE April 12, 1957		PLACE Baltimore		COUNTY Baltimore	

BUREAU V. S.

APR 12 1957

RECEIVED

CERTIFICATE OF DEATH

04326.

Reg. Dist. No. 215

4327

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>China</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>75 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taipei-Formosa 90X-3</u>			
d. STREET ADDRESS <u>2 Lane 245 Shu-Lane Nanking Road-T</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kuang</u> Middle <u>Yao</u> Last <u>WANG</u>				4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Chinese</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 Feb. 1910</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier (Maj. Gen.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Free Chinese Army</u>		11. BIRTHPLACE (State or foreign country) <u>China</u>	
12. CITIZEN OF WHAT COUNTRY? <u>China</u>							
13. FATHER'S NAME <u>In Chu WANG</u>				14. MOTHER'S MAIDEN NAME <u>Chen Chu CHING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, Pulmonary</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, Bronchogenic</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>9 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Feb.</u> , 19 <u>57</u> , to <u>25 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 April</u> , 19 <u>57</u> , and that death occurred at <u>8:50</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>				DATE SIGNED <u>4-26-57</u>			
ACTUAL SIGNATURE <u>R. J. Mc Carthy</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u>				ADDRESS <u>755 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>4-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.
APR 29 1964

RECEIVED
APR 29 1957

1

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4328

4328

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04327
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. Wash.</u> b. COUNTY <u>Washington DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Hospital Sanitarium</u>		d. STREET ADDRESS <u>5211-39 St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Sylvestro</u> First <u>A</u> Middle <u>Hard</u> Last		4. DATE OF DEATH <u>April 9th</u> 19 <u>57</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1893</u> 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Construction Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Penna</u>	
13. FATHER'S NAME <u>John Ward</u>		14. MOTHER'S MAIDEN NAME <u>Jane Mackey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Dr Crowley 5211 39th NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFECTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY HEART DISEASE</u> DUE TO (c) <u>EMPHYSEMA CHRONIC</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>10+ YRS.</u> <u>20+ YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1 CONGESTIVE HEART FAILURE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/7/1957</u> to <u>4/9/1957</u> , that I last saw the deceased alive on <u>4/7/1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.		ADDRESS (Street, city or town, state) <u>4811 Battery Lane</u> DATE SIGNED <u>4/9/57</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, Jr Bethesda, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westminster</u>	22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga Ave NW</u>		24a. REC'D BY REGISTRAR <u>APR 11 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Diabetes Mellitus		Natural		Home		JAN 14 1957		10:15 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's License No.		Physician's Signature	
[Signature]		JAMES EARL RAY		1234 Main St		MOBILE		ALABAMA		UNITED STATES		12345		[Signature]	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's License No.		Medical Examiner's Signature	
[Signature]		JOHN DOE		5678 Elm St		BALTIMORE		MARYLAND		UNITED STATES		67890		[Signature]	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Country		Registrar's License No.		Registrar's Signature	
[Signature]		JOHN DOE		9010 Oak St		BALTIMORE		MARYLAND		UNITED STATES		10987		[Signature]	

RECEIVED
APR 11 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

04328
 (04328)
 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>ANNE ARUNDEL Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 03X02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ASBURY METHODIST HOME</u>				d. STREET ADDRESS <u>26 Sherwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth WAREHEIM</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 29 1873</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		9. AGE (In years last birthday) yrs. <u>84</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>WESTMINSTER, CARROLL, Co.</u>			
13. FATHER'S NAME <u>MILTON DEVLBISS</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA WARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-32-1218A</u>		17. INFORMANT Address <u>Mr. Paul E. Wareheim-706 Brookwood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE & CONGESTIVE FAILURE</u> DUE TO (c) <u>BILATERAL PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 18</u> , 1957, to <u>APRIL 8</u> , 1957, that I last saw the deceased alive on <u>APRIL 6</u> , 1957, and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4208 Anthony ST. Kensington Md. 4/16/57</u>			
PHYSICIAN'S NAME (Type) <u>Sarah E Glover</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. J. Tichenor & Sons, Balt.</u>				24a. REC'D BY REGISTRAR <u>APR 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alvina Hooks</u>	

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BUREAU V.

APR 16 1957

RECEIVED

4196

CERTIFICATE OF DEATH

Reg. Dist. No.

27-3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. Hosp.</u>				d. STREET ADDRESS <u>581 University Blvd. E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>none</u> Last <u>Weidlich</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-79</u> 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Julius Schoenfeldt</u>				14. MOTHER'S MAIDEN NAME <u>Pauline JUNCHANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Charles W. H. H.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral & Vascular Encephalopathy</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Diabetes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u> <u>4 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis 15 yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 8, 1956</u> , to <u>Apr 5, 1957</u> , that I last saw the deceased alive on <u>Apr 5, 1957</u> , and that death occurred at <u>10:23 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>934 Silver Spring Dr.</u> DATE SIGNED <u>4-5-57</u>			
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>				ADDRESS <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Soldiers Home Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 2a Ave. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilcox</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS INJURY		PREVIOUS SURGERY		PREVIOUS TREATMENT		PREVIOUS MEDICATION		PREVIOUS DIET		PREVIOUS EXERCISE		PREVIOUS OCCUPATION		PREVIOUS HOBBIES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF INTERVIEWER		SIGNATURE OF REPORTER		SIGNATURE OF OFFICIAL	

BUREAU V. S.

APR 9 1957

RECEIVED

4197

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ----- b. COUNTY -----			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 18 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia 47x-3			
				d. STREET ADDRESS 6311 Kansas Ave. N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mina Middle (NMN) Last Weikers			4. DATE OF DEATH Month April Day 20 Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH I-24-77		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Aaron Sichel				14. MOTHER'S MAIDEN NAME Yettie Sichel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 9000 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis. Interochondral fracture left hip.							INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Misjudged bottom step at home & fell.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5 p. m. April 19 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington D. C.	
21. I certify that I attended the deceased from April 19, 1957 , to April 20, 1957 , that I last saw the deceased alive on April 20, 1957 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Sydney L. Loretthal				ADDRESS (Street, city or town, state) 7210 Chesapeake Rd., Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Sydney L. Loretthal				DATE SIGNED 4/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 20 1957		22c. NAME OF CEMETERY OR CREMATORY ACHDUTH CHEVRA		22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Langansky				ADDRESS 3501-14 St. N.W.		24a. REC'D BY REGISTRAR APR 23 1957	
				24b. REGISTRAR'S SIGNATURE J. Wilson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04331

Reg. Dist. No. 214

4330

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>1 Year</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4915 Hampden Lane</u>				d. STREET ADDRESS <u>4915 Hampden Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>William</u> Last <u>Wepfer</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1901</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Wepfer</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Zahorka Wepfer</u> Address <u>Norma Gray, Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> DUE TO <u>973.1</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in auto</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in auto in enclosed garage (left Note)</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>4/29/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Transit</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marshfield</u>		22d. LOCATION (City, town, or county) (State) <u>Marshfield, Wis.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 5-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 1

MAY 3 1957

RECEIVED

04332

4331

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 158 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head 08x22				d. STREET ADDRESS 134 Circle Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Shirley Last WHITE				4. DATE OF DEATH Month April Day 16 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 May 1923	
9. AGE (In years last birthday) 33 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Leroy Milsap		14. MOTHER'S MAIDEN NAME Mary E. Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband, Henry Q. White, (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of kidney 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with multiple metastases DUE TO (c) 18 mo.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Nov. , 19 56 , to 16 April , 19 57 , that I last saw the deceased alive on 16 April , 19 57 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Byron D. Casteel M.D. U.S. Naval Hospital, Bethesda, Md. 4-18-57							
ACTUAL SIGNATURE Byron D. Casteel M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) Byron D. Casteel, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4-19-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR 4-17-57		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(2012) 50:1005

BUREAU V. S.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04333

4198

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laborer Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in-hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>14336 Leland St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>W.</u> Last <u>Putnam</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-88</u>	9. AGE (In years lost birthday) <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Joseph Morris Smith</u>				14. MOTHER'S MAIDEN NAME <u>Eltha Connors</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. Edith S. Ross, 4336 Leland St. S.W. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(c) Rheumatic Heart Disease</u> <u>411X</u> DUE TO <u>(b) Aortic Insufficiency, b</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(c) Longstanding Scurvy</u> DUE TO <u>(a) Longstanding Scurvy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>many yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>56</u> , to <u>April 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 6</u> , 19 <u>57</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7401 Blau Road NW</u> DATE SIGNED <u>Nash, D.C.</u>							
ACTUAL SIGNATURE <u>Chas. H. Volohon</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Chas. H. Volohon</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catharine Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Catharine, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Arthur Walters - 254 Carroll St. NW</u>				24a. REC'D BY REGISTRAR DATE <u>4/9/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

4332

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 1317 Woodside Parkway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Herbert Middle A. Last Wilkinson				4. DATE OF DEATH Month 4- Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/07	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist				10b. KIND OF BUSINESS OR INDUSTRY US Government		11. BIRTHPLACE (State or foreign country) South Dakota	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Herbert S. Wilkinson				14. MOTHER'S MAIDEN NAME Margaret DeCon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Katherine (wife) Address 1317 Woodside Parkway Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonic Miltid Disease DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Dysfunction (old)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 21, 1947 , to April 10, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 1:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8248 Georgia ave. Silver Spring, Maryland DATE SIGNED 4/10/57							
ACTUAL SIGNATURE Merrill M. Cross M.D.							
PHYSICIAN'S NAME (Type) MERRILL M. CROSS				Silver Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF April 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey				ADDRESS 5434 Georgia ave Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 4-11-57	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED

NAME OF DECEASED

NAME OF DECEASED

DATE OF DEATH

DATE OF DEATH

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BUREAU V. 3

APR 15 1957

RECEIVED

4199

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rt Frederick 10x12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie Elizabeth Wilks</u>				4. DATE OF DEATH Month Day Year <u>April 11 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W Iddings</u>				14. MOTHER'S MAIDEN NAME <u>Effie Virginia Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis & pleural effusion - massive - bilateral</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis - Abdomen & Chest</u> DUE TO (c) <u>Carcinoma of both Ovaries</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos ±</u> <u>6 mos ±</u> <u>9 mos ±</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none recently</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 8, 1957</u> to <u>April 11, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred at <u>8:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Read N. Calvert</u> M.D.				ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., M.D.</u>			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>				ADDRESS <u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son</u>				ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>4/15/57</u>	
24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1957

RECEIVED

4333

CERTIFICATE OF DEATH

Reg. Dist. No.

0433676

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Weehawken 67x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 883 Boulevard East	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Louise Wood		4. DATE OF DEATH Month Day Year 4 6 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83 yrs.
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Raneshousen		14. MOTHER'S MAIDEN NAME Harriet Tower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice Webster, 883 Boulevard, Weehawken, N. J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Uremia</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular renal disease</u> DUE TO (c) <u>Advanced arterio-sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1957, to 4-6-1957, that I last saw the deceased alive on 4-5-1957, and that death occurred at 12:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3921 Ingomar St. N.W. 4-6-57 wash 15 D.C.			
ACTUAL SIGNATURE Stewart Clapp		M.D.	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4/6/57	22c. NAME OF CEMETERY OR CREMATORY Pittsfield Cemetery	22d. LOCATION (City, town, or county) (State) Pittsfield, Mass.
23. FUNERAL DIRECTOR'S SIGNATURE St. Annes Co		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Renee Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. MEDICAL HISTORY		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR		12. DATE OF DEATH	
13. PLACE OF DEATH		14. TIME OF DEATH	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL OFFICIAL	
19. SIGNATURE OF CHURCH OFFICIAL		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF CEMETERY		22. SIGNATURE OF INTERMENT	
23. SIGNATURE OF BURIAL		24. SIGNATURE OF CREMATION	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER	
27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER	
35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER	
39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER	
45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER	
47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER	
53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER	
57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER	
59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER	
63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER	
65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER	
75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER	
83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER	
87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER	
95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER	
99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

BUREAU V. 8.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04337
223

4200

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs.</u> 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Celshington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>103 Woodridge Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Junius</u> Middle <u>Boyd</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-77</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Correspondent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>News paper</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Samuel Wood</u>			
14. MOTHER'S MAIDEN NAME <u>Eleanor Boyde</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>No</u>			
16. SOCIAL SECURITY NO. <u>yes</u>				17. INFORMANT <u>Wife</u> Address <u>Same as Deceased</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> , to <u>Apr 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 2</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.				ADDRESS (Street, city or town, state) <u>9601 Coleville Rd</u> DATE SIGNED <u>Apr 2-57</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				SILVER SPRING MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>4/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>8434 Galine</u>			
24a. REC'D BY REGISTRAR <u>APR 3-1957</u>				24b. REGISTRAR'S SIGNATURE <u>Wilson Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

APR 8 1957

RECEIVED

1

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4334

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Box 319			
3. NAME OF DECEASED (Type or print) First Jackie Middle Lynn Last Wyatt				4. DATE OF DEATH Month April Day 16 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 24, 1956	
9. AGE (In years lost birthday) yrs. 4		10. IF UNDER 1 YEAR Months 4 Days 23 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jackie Wyatt				14. MOTHER'S MAIDEN NAME Virginia Bolton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute anoxia 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congenital cyanotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 10 , 19 57 , to April 16 , 19 57 , that I last saw the deceased alive on April 16 , 19 57 , and that death occurred at 4:32 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/17/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit				22b. DATE THEREOF 4/17/57		22c. NAME OF CEMETERY OR CREMATORY Princeton, W. Virginia	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 4-18-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar before to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVVVXVV

RECEIVED

APR 22 1957

BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4335

CERTIFICATE OF DEATH

Reg. Dist. No.

043324

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>407 HINSDALE LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGUERITE E. YANICK</u>		4. DATE OF DEATH Month Day Year <u>Apr 13 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1911</u>
9. AGE (In years lost birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dalzell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret K Knode</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Richard J Yanick</u>		Address <u>407 Hinsdale Lane Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis, myocardial infarction</u> DUE TO (c) <u>See arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>54</u> to <u>9/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>57</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>St. Courtney</u> M.D. <u>5601-4th St</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>F. X. COURTNEY M.D. Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>4-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Fort Lincoln</u>		<u>Blodensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Deaf Funeral Home</u>		<u>4812 Ga Ave NW Wash DC</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>APR 18 1957</u>		<u>Frances Tatter</u>	

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04340

CERTIFICATE OF DEATH

Reg. Dist. No.

217

4336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp.</u>		d. STREET ADDRESS <u>2315 Homestead Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Hae</u> Middle <u>C</u> Last <u>Zebley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Corry, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. R. Bouee</u>		14. MOTHER'S MAIDEN NAME <u>Jucine Raymond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jucine Raymond</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme emaciation due to 194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of thyroid with metastasis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>18 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Dec. 14</u> , 19 <u>56</u> , to <u>Apr. 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr. 21</u> , 19 <u>57</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John B. Zebley</u> M.D.	ADDRESS (Street, city or town, state) <u>Olney, Md.</u> DATE SIGNED <u>April 22, 1957</u>
PHYSICIAN'S NAME (Type) <u>John B. Zebley</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>4/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>APR 24 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Gertude Lawler</u>

RECEIVED

APR 24 1957

BUREAU V. B.

Dec-14 20 1957

John B. Ziegler

Lucine Rademacher -

Court, Penna - W. 8. 22 -

Gold 33, 1884 20

April 22 22

212 Homestead Drive

Silver Spring

Washington

D. R. Bone

F. White

4/22

Brooks Grove Church Hosp -

W. 8. 22 -

Washington